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JOURNAL of the Medical Association of the State of ALABAMA



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AMYTAL TAKES THE EDGE OFF DAYTIME ANXIETY AND TENSION

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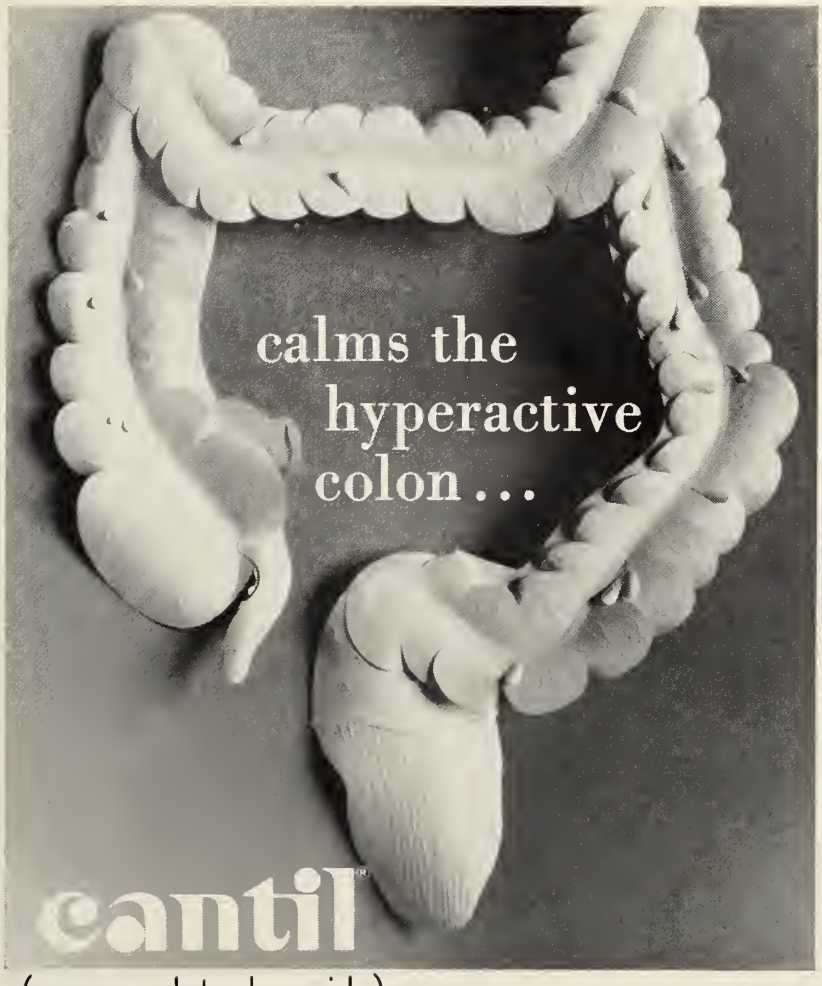
Contraindication: Pediamycin is contraindicated for patients with known sensitivity to erythromycin.

Precautions: Side effects are relatively rare. Should a patient show signs of hypersensitivity, appropriate countermeasures (e.g., administration of epinephrine, steroids, etc.) should be employed and the drug withdrawn.

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*Done, A. K., in Drugs of Choice 1964-1965, Modell, W., ed., St. Louis, The C. V. Mosby Co., 1964, p. 66.

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1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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FAMOUS ALABAMA PHYSICIANS



DR. JOHN ALLAN WYETH (1845-1922) was a native Alabamian who went to New York and became well known through his professional activities. He is probably best known for founding the first post-graduate medical school in the United States.

John Allan Wyeth was born in Marshall County May 26, 1845 at a Cherokee Missionary Station which was founded by the Presbyterian Church. He spent a normal childhood, attending school at Guntersville and earning money by cutting wood in his father's forest and selling it to people in town. With some of this "spending money," he became an early subscriber to Harper's Magazine and Harper's Weekly.

When he was 15, young Wyeth entered LaGrange Military Academy in Franklin County. His college career ended in December, 1861 after one year of training.

The state had seceded and the Confederacy had been organized during his year at college. Despite protests from his parents, John Allan enlisted in the Confederate cavalry. He took part in numerous engagements and finally was taken prisoner in 1863 and confined at Camp Morton, Indiana.

In the fall of 1867 Wyeth entered the freshman medical class of the University of Louisville. The curriculum included anatomy, chemistry, physiology, materia medica, medicine, surgery and obstetrics. The teaching of most of the subjects was largely didactic but the anatomy course was supplemented by good work in the dissecting room.

The degree of Doctor of Medicine was conferred upon John Allan Wyeth March 2, 1869. He returned to Guntersville and opened an office. He was quite successful with his first cases but a case of diabetes mellitus which progressed to a fatal termination was too much for him. Feeling that he was unfit to take the responsibility of the life, health and happiness of those who might be willing to place themselves in his care, he decided to close his office until he could get additional clinical and laboratory training.

Discovering that there were no special courses offered to graduates in medicine, Dr. Wyeth matriculated at Bellevue Hospital Medical School in New York and graduated in March, 1873.

He became assistant demonstrator of anatomy in 1873 and in 1874 he was appointed prosecutor to the chair of anatomy. In 1875 he began the study of pathology with Dr. E. G. Janeway and joined the New York Pathological Society. This group later honored him by making him president for two terms in 1895 and 1896.

Dr. Wyeth's studies and papers earned him many awards and in 1877 he was appointed visiting surgeon to St. Elizabeth's Hospital. In 1880 he received a similar appointment to Mt. Sinai Hospital.

In 1881, Dr. Wyeth founded the New York Polyclinic Medical School and Hospital, the first postgraduate medical school in America. He became Professor of Surgery and Surgeon in Chief and later on president of the institution.

In 1901, Dr. Wyeth was elected president of the American Medical Association. He also served as president of the New York Academy of Medicine and the New York Southern Society.

Dr. Wyeth died suddenly of heart disease May 8, 1922 and with him passed one of America's pioneers, a great surgeon. He organized techniques that have been extremely helpful in the relief of human pain and suffering, as well as improved and devised corrective surgical methods. A bronze statue of Dr. Wyeth stands on the grounds of the Capitol in Montgomery.

One of a series of Famous Alabama Physicians based on research compiled by Dr. E. B. Carmichael for

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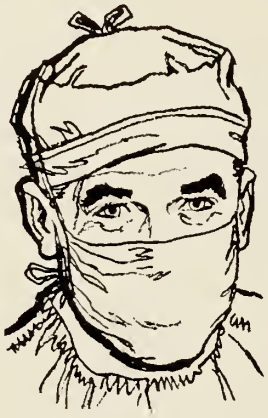
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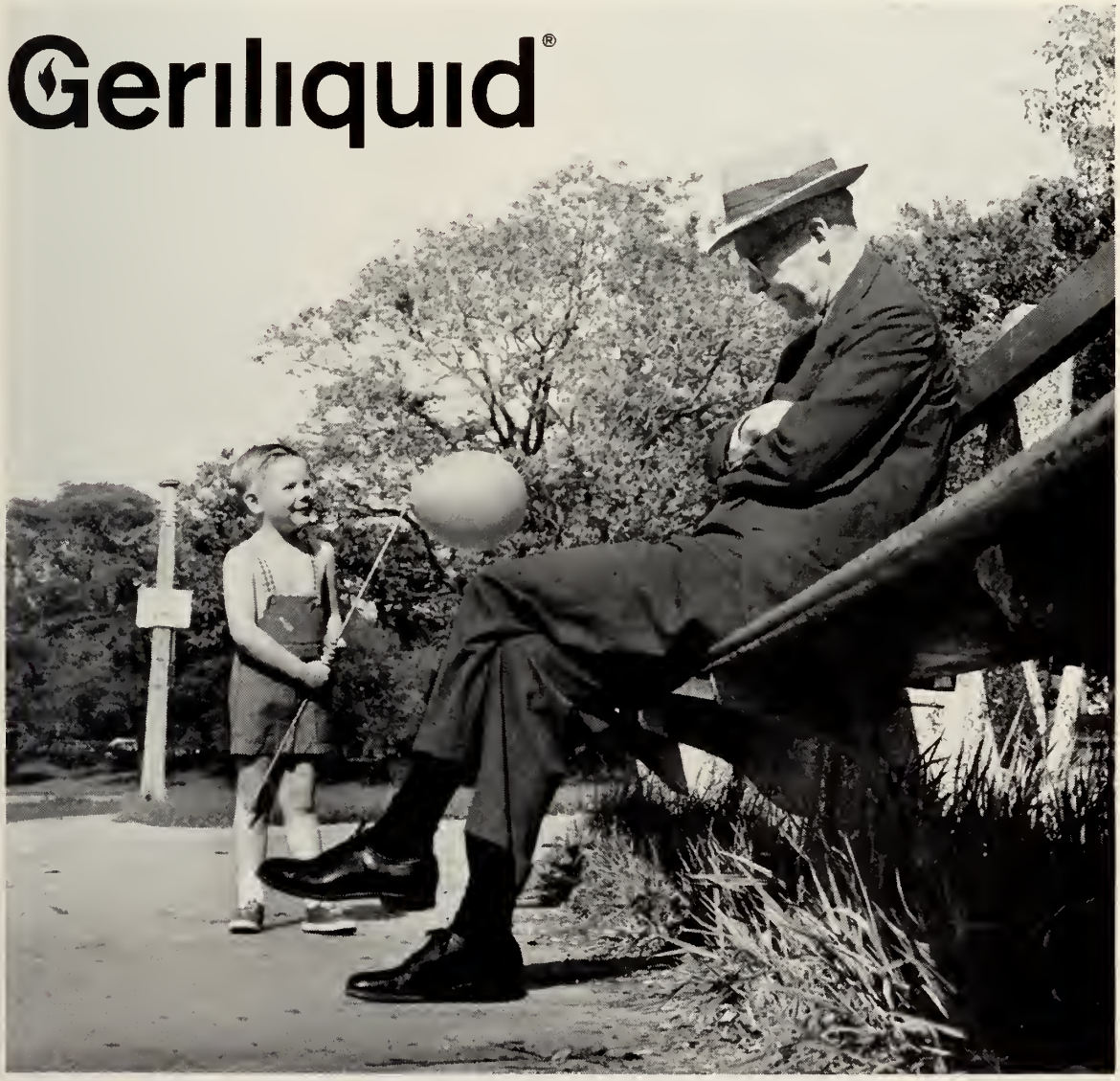
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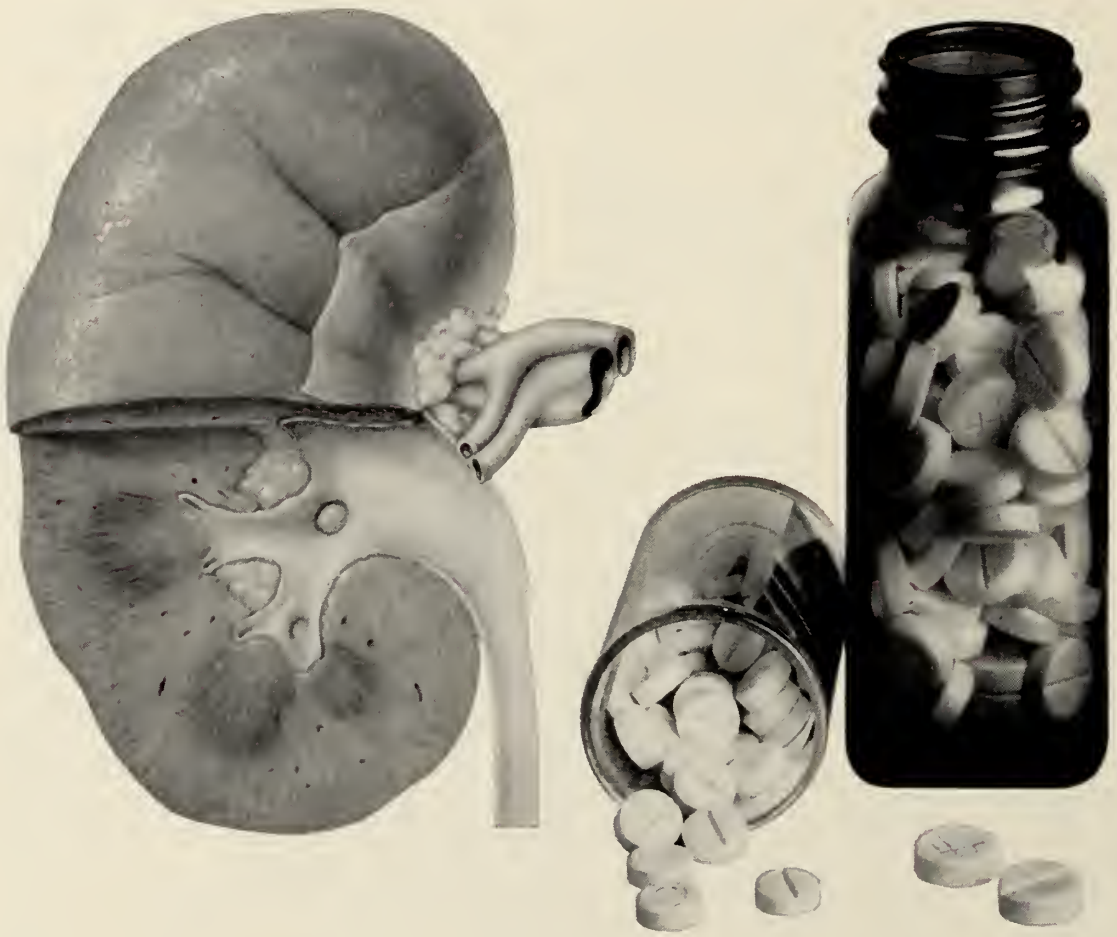
Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.

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PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

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(iron dextran injection)



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President's Page



Upon the occasion of his retirement as Health Officer for Mobile County, Dr. Otis L. Chason prepared a most important RESOLUTION, published on page 55 of this *Journal*, which was first adopted by the Medical Society of Mobile County and later by the Medical Association of the State of Alabama in April, 1965. He first called attention to the poor financial support of the Departments of Health both at State and County levels despite increasing popular awareness of the importance of public health and increasing demand for services. He states that the result is, "inadequacy of personnel, in number and often in qualification," and significant, "deficiencies of services." Dr. Chason then described how the City of Mobile in 1841, and later the State of Alabama in 1875, established our most outstanding system whereby the Medical Association of each County and the Medical Association of the State of Alabama is legally established as the official Board of Public Health. He makes the very important point that this system constitutes a significant gift of medically educated personnel to judge the public health needs throughout the State and that these most highly qualified Boards of Health are no less an official agency of the State Government and of each County and Municipal Government than are any other legally constituted Boards. This Public Health Organization has, through the years, been considered a model for public health organizations throughout the United States and the world because of the fact that the most highly qualified individuals in the State, namely the members of the medical profession of the State, by legal designation are in charge of the health activities.

Dr. Chason called upon the Medical Association to declare again its full support of the public health program for which we are responsible. In addition, he asked that we and the public earnestly solicit the support of the governing bodies of the State, Counties, and Municipalities because these Boards of Public Health are not just committees of doctors, but are official agencies of the government and serve only for the best good of the people of the State of Alabama and its various counties and municipalities.

On June 2nd, 1965, a delegation from the Medical Association of the State of Alabama, conferred with Governor George C. Wallace in his office in Montgomery concerning the serious needs of our State Department of Public Health. These needs had been clearly outlined by Dr. Ira L. Myers, State Health Officer, at the mid-year meeting of Counsellors and Delegates in the fall of 1964, and subsequently at sectional meetings throughout



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*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

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IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

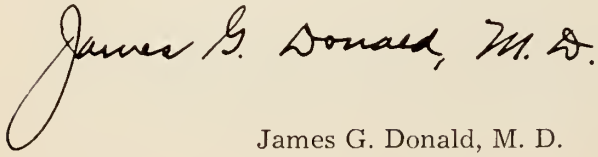
PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

the State. The budget which has recently been proposed by Governor Wallace for the coming year gave only about $500,000.00 increase for the Department of Public Health, rather than the increase of $2,000,000.00 which Dr. Myers felt would be necessary to fulfill his minimum needs. In addition, Dr. Myers had requested a bill to abolish the salary ceilings for professional personnel in the Department of Health so that, at the discretion of the Board of Health and the Personnel Board, salaries for professional personnel within the Department could be set at a level sufficient to procure and retain well qualified individuals. This bill had been introduced into both chambers of the Legislature, but had been held in committee prior to our meeting with Governor Wallace. Our delegation was accompanied by Representative Albert Brewer and Representative Alton Turner, both of whom are sympathetic to our needs. Governor Wallace received us cordially and immediately let us know that he was in complete sympathy with the needs of the Department of Public Health and would do all that he could to help meet these needs. He immediately gave his support to the salary bill which would abolish the ceilings for professional personnel in the Department of Public Health and which Dr. Myers considers to be the essential first step in upgrading his organization. In addition to this, Governor Wallace has requested a meeting with Representative Albert Brewer and Representative Alton Turner to go over the funds available in the General Fund of the State to try to find as much additional appropriation for the Department of Public Health as is possible this year. He fully recognizes the importance of this Department to the health needs of the people of Alabama and indicated his willingness to help us meet these needs.



James G. Donald, M. D.

Reprints Available For Birth Defects Series

The National Foundation—March Of Dimes has announced a new Birth Defects Reprint Series. The reprints are of articles which have appeared in scientific and medical literature publishd in the United States and abroad. The first group of reprints is ready for distribution and includes the following:

Allan C. Barnes, M. D. Prevention of Congenital Anomalies from the Point of View of the Obstetrician—from the Proceedings of the Second International Conference on Congenital Malformations, July 1963, Code No. PE-RS 1.

Leslie C. Dunn, Sc. D. Old and New in Genetics—from Bulletin of The New York Academy of Medicine, May 1964, Code No. PE-RS 2.

James L. German, M. D. The Pattern of DNA Synthesis in the Chromosomes of Human Blood Cells—from Journal of Cell Biology, January 1964, Code No. PE-RS 3.

Kurt Hirschhorn, M. D. Recent Advances in Methodology of Human Genetics—from Bulletin of The New York Academy of Medicine, May 1964, Code No. PE-RS 4.

Henry N. Kirkman, M. D. Genetic Control of Human Enzymes—from Pediatric Clinics of North America, May 1963, Code No. PE-RS 5.

Norman Kretchmer, M. D. Whither Birth Defects?—from Perspectives in Biology and Medicine, Autumn 1946, Code No. PE-RS 6.

R. James McKay, Jr., M. D. and Jerold F. Lucey, M. D. Neonatology—from New England Journal of Medicine, June 4 and 11, 1964, Code No. PE-RS 7.

Severo Ochoa, M. D. The Chemical Basis of Heredity—The Genetic Code, from Bulletin of The New York Academy of Medicine, May 1964, Code No. PE-RS 8.

Joseph P. Rossi, M. D. High Risk Babies: Determining the Problem—from Connecticut Health Bulletin, November 1964, Code No. PE-RS 9.

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But with plenty of farming and some careful planning, he always has managed to see that the needs of the children were met.

Dr. Partlow, who passed the three score and ten mark several years ago, is now leaving the Alabama State Hospitals which he has served for 53 years. He started at Bryce, was later sent to Mt. Vernon for two years, then returned to Bryce. He spent 30 years as a staff physician there before taking over at Partlow in 1944.

He has seen good days and many trying ones, at Partlow. Under his leadership the staff is larger now than at any time in the institution's history with more physicians, nurses and other professional personnel.

After 53 years of medicine, it would seem only right for Dr. Partlow to sit back and take life easy. But that's not the way he operates. He now plans to work with professional, volunteer groups to seek additional ways to aid the mentally retarded.

Dr. Partlow was honored at the semi-annual meeting of the Patrons of Partlow. But there is no real way that he can be repaid for all he has done for the mentally retarded and handicapped children of Alabama.

This editorial reprinted from the *Tuscaloosa News*, Tuscaloosa, Alabama

Mr. L. P. Patterson, Assistant Executive Secretary, and Managing Editor of the *Journal*, continues to improve after a coronary thrombosis suffered on May 28.

"Pat" will be at home, 3529 Cambridge Road, Montgomery, Alabama, by the time this issue reaches you.

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1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. *8*:73-77 (Jan.) 1957

2—Asher, L.M.: Am. J. Digestive Diseases *4*:272 (Apr.) 1959

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Progress In The Study Of Rheumatic Diseases: New Drugs*

Frank Lehn, M. D.**

Birmingham, Alabama



Three new drugs of considerable promise have been recently introduced into the armamentarium for the therapy of rheumatic diseases. Each is important in a separate area of rheumatology and each has a particular mode of action.

Allopurinol (4-hydroxypyrazolo (3-4d) pyrimidine) is a potent xanthine oxidase inhibitor that was originally utilized to suppress the oxidation of 6-mercaptopurine to 6-thiouric acid. It proved to be an effective inhibitor of this reaction and much smaller doses of 6-mercaptopurine could be given in conjunction with allopurinol.

Investigators also noted that, concomitant with the administration of allopurinol, a marked depression in serum and urinary uric acid levels occurred.[1] This decline results from the simultaneous suppression of the conversion of hypoxanthine and xanthine to uric acid.

*This investigation was supported by Public Health Service Grants T1 AM 5000 and AM 03555 from the National Institute of Arthritis and Metabolic Diseases, Bethesda, Maryland.

**From the Division of Rheumatic Diseases, Department of Medicine, University of Alabama Medical Center, Birmingham, Alabama.

$$\text{Hypoxanthine} \xrightarrow{\text{Xanthine Oxidase}} \text{Xanthine} \xrightarrow{\text{Xanthine Oxidase}} \text{Uric Acid}$$

Xanthine and hypoxanthine levels increase in the serum and urine, as would be expected when allopurinol is administered.

Viewing this effect on uric acid metabolism, a clinical trial in patients with primary gout[2] was then carried out. This trial was successful in lowering serum and urinary uric acid levels in all patients. Interestingly, those patients with the highest serum uric acids have been found to respond with the greatest percentage fall in serum and urinary uric levels.

Yu and Gutman[1] have recently published their results using allopurinol in a group of 50 patients with primary and secondary gout who had been fairly refractory to conventional measures of uricosuric therapy.

The dosage necessary to lower serum uric acid in this study was 300 mgm per day in 70 per cent; from 400 to 600 mgm per day in the remaining 30 per cent. They found that uric acid levels were markedly depressed in blood and urine, urolithiasis was halted, tophus formation ceased and, in a few cases, some tophi were found to regress while on therapy. Allopurinol had no effect on acute gouty arthritis, possessing no inherent anti-rheumatic properties.

Addition of a uricosuric agent resulted in further lowering of serum uric acid levels, with a slight increase in urinary uric acid levels and decrease in urinary hypoxanthine and xanthine levels.

The most serious side effect of allopurinol therapy has been exacerbation of acute gouty arthritis, apparently caused by mobilization of body urate stores.[3] For this reason, accompanying colchicine therapy is advisable. Other side effects included mild gastrointestinal irritation and liver function disorders but no serious side effects have been noted to date. Xanthine or hypoxanthine stones have not been reported.

Allopurinol's introduction would appear to be a significant addition to the therapy of both primary and secondary gout and should prove an effective agent in the management of these entities. The beginning dosage should be 100 mgm three times daily with incremental increases if this dosage is ineffective in lowering the serum uric acid.

Indomethacin (1- (p-chlorobenzoyl)-5-methoxy-2-methyl-indole-3-acetic acid) is a new anti-inflammatory drug that has been subjected to a number of extensive clinical trials in the past two years. In these trials, it has been found to be a potent antirheumatic drug but has had a number of unpleasant side effects. However, dosages used were higher than would now be prescribed and probably were responsible for the high incidence of such side effects as headache, gastrointestinal irritation, dizziness, skin rash and neutropenia. Interestingly, the use of capsules rather than tablets has also been noted to decrease the incidence of side effects.[4]

A number of investigators have found indomethacin of particular value in ankylosing spondylitis.[5, 6, 7] In one report,[5] patients obtained marked relief of pain and stiffness as early as 24-48 hours after starting the drug.

The dosages utilized ranged from 100-200 mgm per day. One report[4] revealed that toxic effects were markedly reduced if the dosage was kept below 100 mgm per day. Kelly[8, 9] believes that a dosage of 50-100 mgm per day is the optimum but, even that at this dosage, two out of five patients will suffer mild side effects. The development of drug tolerances was noted in several of his patients, requiring either discontinuance and then re-starting or alternating with another drug such as phenylbutazone.

Indomethacin's efficacy in acute gout has been demonstrated by several workers.[6, 8, 10] Smyth[10] has successfully utilized large doses ranging from 500-900 mgm the first 24 hours and then tapering to 300 to 400 mgm for the next two to four days. One of his patients had probable pseudogout in which symptomatic relief was also good. The other authors[6, 8] did not use this high dosage, but had comparable results, as most patients ob-

tained relief within 24-48 hours after beginning therapy.

Results in rheumatoid arthritis, osteoarthritis, and other rheumatic diseases have been less dramatic and reported results have ranged from excellent to indifferent. It would seem from the survey of these reports that a trial of therapy would be justified in a patient not responding to a conservative program of physical therapy, rest, and salicylates. However, the therapeutic response might be expected to be extremely variable.

The only contraindication reported has been the existence of peptic ulcer disease. The reported experience of most investigators is that administration of indomethacin results in exacerbation or worsening of the symptoms of peptic ulcer disease.

Dimethyl sulfoxide (DMSO) is a clear, colorless material that has been utilized for years as a commercial solvent. In the past two years, a burgeoning interest has developed in this compound for it appears that it may become a valuable addition to the present therapeusis of rheumatic diseases.

A preliminary report[11] in February, 1964 described a wide variety of possible medical usages, numbering among them a diuretic, a tranquilizing, a bacteriostatic, a potentiating or synergistic effect with other drugs; as well as an enhanced absorptive, anti-inflammatory and a local analgesic effect. These last three properties could be invaluable in the treatment of rheumatic diseases if side effects are minimal enough to warrant continuous usage.

Rosenbaum and Jacob[12, 13] have described their initial results in the therapy of rheumatic diseases. Nine of ten patients with acute subdeltoid bursitis had almost complete relief of their bursitic symptoms within 20 minutes of topical application to the bursa area. The relief of symptoms ranged from four hours to an indefinite period. They have also obtained good results in treating degenerative arthritis of the knee with relief of pain after one week of topical therapy in five of six patients.

Their results in rheumatoid arthritis have been inconsistent,[14] as have been those of others[15, 16] who have treated such patients. Four gouty patients have been treated to date with good results, as manifest by relief of pain in the involved joints after local application of the drug.

The toxicities described[14, 16] so far have included elevations of serum glutamic oxaloacetic transaminase, serum glutamic pyruric transaminase, indirect bilirubin and BUN, reduction of platelets and skin eruptions ranging from localized to generalized. Several patients have complained of such severe burning over the site of application of 99.6 per cent DMSO that it had to be removed with water.

Current investigations have emphasized therapy of acute "strain," acute bursitis of the shoulder, acute soft tissue trauma and osteoarthritis of the knee with this drug. No large group of patients have been subjected to long-term controlled studies to date. Further studies as to the ultimate therapeutic value of DMSO in the therapy of musculoskeletal disease are indicated.

Our experience at the University of Alabama Medical Center has been small at the time of this writing, but at least two patients with acute bursitis of the shoulder have responded with dramatic relief of symptoms.

Two patients with muscle spasm have also responded dramatically. One of these complained of a burning sensation over the site of application, but no other side effects have been noted to date.

DMSO is supplied as a 90 per cent solution but is not available yet except as an experimental drug. It is applied with plain cotton tip applicators until the involved area is covered. The drug is then allowed to dry for 20 minutes. The patient is cautioned not to allow clothing to touch this area nor should any other medication be allowed on this area for it is both a potent solvent and topical vehicle for other drugs. The application may

be repeated two or three time per day but should not exceed 6 cc in any one application.

References

1. Yu, T. and Gutman, A. B. Effect of allopurinol (4-hydroxypyrazolo-(3,4-d) pyrimidine) on serum and urinary uric acid in primary and secondary gout. Amer. J. Med. 37: 885-898, Dec., 1964.

2. Rundles, R. W., et al. Effects of a xanthine oxidase inhibitor on thiopurine metabolism hyperuricemia and gout. Trans. Ass. Amer. Physicians 86: 126-140, 1963.

3. Hall, A. P., Holloway, V. P. and Scott, J. T. 4-hydroxypyrazolo (3,4-d) pyrimidine (HPP) in the treatment of gout: preliminary observations. Ann. Rheum. Dis. 23: 439-446, Nov., 1964.

4. Today's drugs: indomethacin. Brit. Med. J. 2: 429, Aug. 15, 1964.

5. Bilka, P. J., Wollheim, F. and Williams, R. C., Jr. Indomethacin: a new antirheumatic agent. Minnesota Med. 47: 777-781, July, 1964.

6. Wanka, J., et al. Indomethacin in rheumatic diseases. A controlled clinical trial. Ann. Rheum. Dis. 23: 218-225, May, 1964.

7. Boland, E. W. Nonspecific anti-inflammatory agents. Some notes on their practical application, especially in rheumatic disorders. Calif. Med. 100: 145-155, March, 1964.

8. Kelly, Michael. Indomethacin, remarkable antirheumatic drug. Med. J. Aust., II: 541, Oct. 3, 1964.

9. Kelly, M. Indomethacin: an antirheumatic drug. Lancet 2: 474-475, Aug. 29, 1964.

10. Smyth, C. J., Veloyos, E. E. and Amoroso, C. A method for measuring swelling of hands and feet. II. Influence of new anti-inflammatory drug, indomethacin, in acute gout. Acta Rheum. Scand. 9: 306-322, 1963.

11. Jacob, S. W., Bischel, M. and Herschler, R. J. Dimethyl sulfoxide (DMSO): A new concept in pharmacology. Curr. Ther. Res. 6: 134-135, Feb., 1964.

12. Rosenbaum, E. E. and Jacob, S. W. Dimethyl sulfoxide (DMSO) in acute musculoskeletal injuries and inflammations. I. Dimethyl sulfoxide in acute subdeltoid bursitis. Northwest Med. 63: 167-168, March, 1964.

13. Ibid 63: 227.

14. Rosenbaum, E. E., Jacob, S. W. Dimethyl sulfoxide in the treatment of osteoarthritis, rheumatoid arthritis and gout. Arthritis Rheum. 7: 340, June, 1964. (Abstract).

15. Bottomly, D. R., Shimazaki, Y., and Bachman, D. M. Controlled study of dimethyl sulfoxide effects in patients with connective tissue diseases. Arthritis Rheum. 7: 294, June, 1964. (Abstract).

16. Bachman, D. M., Bottomly, D. R., and Shimazaki, Y. Additional observations of dimethyl sulfoxide effects in patients with connective tissue disease. Arthritis rheum. 7: 725, December, 1964. (Abstract).



Acute Renal Failure

Henry C. Hudson, M. D., FACS*

Carraway Methodist Hospital, Birmingham, Alabama

Acute renal failure may be defined as a disturbance in which, as a result of toxic, circulatory or other factors, there is sudden profound impairment or cessation of renal function.

Causes of acute renal failure

The main causes of acute renal failure are relatively few: bilateral cortical necrosis, bilateral renal infarction, bilateral hemorrhagic papillary necrosis, acute glomerulonephritis and acute tubular necrosis.

Dehydration

One of the most common causes of moderately severe oliguria encountered is dehydration, with or without salt depletion.

Prerenal failure

Prerenal failure is reversible at first but can cause parenchymal damage which may be irreversible. Prerenal failure results from a sudden fall in blood flow from circulatory insufficiency which may be due to (1) contraction of the blood volume or (2) peripheral vascular shock.

Contracture of blood volume

(a) Blood loss from trauma, surgery, and G. I. bleeding

(b) Loss of red blood cells from hemolysis

(c) Fluid loss from vomiting, diarrhea, burns, and edema of negative protein balance

Peripheral Vascular Shock

(a) Neurogenic shock

(b) Sepsis

(c) Myocardial failure

Bilateral Renal Cortical Necrosis

This condition is most often found in association with disorders of pregnancy, particularly separation of the placenta occurring with pre-eclampsis or eclampsis.

Bilateral Renal Infarction

This may be caused by atheromatous changes in the aorta and renal arteries and clots in the renal arteries. Aneurysm of the aorta may lead to obstruction of the renal vessels. Thrombosis of the renal veins or of the inferior vena cava at the level of the renal veins can produce hemorrhagic infarction of the kidneys.

Acute Glomerulonephritis

This condition is rarely responsible for marked oliguria or anuria. Glomerular filtration may be markedly diminished while there is relatively little tubular damage. The specific gravity tends to be high and the pH acid. In contrast, in acute tubular necrosis there is most often a fixed specific gravity at 1.010 and the pH is usually 5.5 to 7.5. Proteinuria, hematuria, and cylindruria are present.

Papillary Necrosis

Acute pyelonephritis of the type designated "hemorrhagic papillary necrosis" usually occurs in patients suffering from diabetes mellitus or from urinary tract obstruction or both. It is characterized by dysuria, urgency,

*Presented at the meeting of the Southern Society of Urological Surgeons. Sea Island, Georgia, June 11-14, 1964.

frequency, chills, fever, flank pain, pyuria, bacteruria, and occasionally voiding of bits of necrotic tissue. It may be associated with oliguria and azotemia.

Parenchymal Renal Failure

Another term is acute tubular necrosis. In this condition there is marked tubular necrosis with little glomerular damage.

The etiology of acute tubular necrosis is dependent on three factors: (1) Renal ischemia; (2) Pigments liberated by the destruction of red blood cells and muscle following trauma, burns, incompatible transfusions and hemolysis; (3) Nephrotoxins. Nephrotoxins produce acute tubular necrosis by a direct effect on the renal parenchyma, whereas all other causes of acute tubular necrosis are associated with renal ischemia coupled with liberation of pigments, sepsis or unknown factors.

Acute Tubular Necrosis

Acute tubular necrosis (lower nephron nephrosis, hemoglobinuric nephrosis, mercurial nephritis, shock kidney, transfusion kidney, etc.) may result from a large number of causes:

1. (a) Hemolytic transfusion reactions
 (b) T. U. R. with absorption of water
 (c) Quinine sensitivity
2. (a) Muscle damage (myoglobinemia "crush syndrome")
 (b) Non-traumatic muscle ischemia
 (c) Electric injury to muscle
3. Thermal injuries
 (a) Burns
 (b) Heat strokes
 (c) Hyperthermia
4. Hypotension or circulatory collapse from any cause (renal ischemia)
5. Utero-placental damage
6. Septic abortion
7. Alkalosis due to vomiting or ingestion or alkali
8. Brain lesions
9. Poisons
 (a) Carbon tetrachloride
 (b) Potassium bromate (home permanents)
 (c) Antifreeze
 (d) Poisonous mushrooms
 (e) Pesticides
 (f) Tartrate
 (g) Metallic poisons—mercury, bismuth, etc.

Obstruction (Post renal failure)

Total anuria is uncommon. It indicates obstruction, a massive renal accident, or acute severe glomerulonephritis. The first step in diagnosis is to determine that no obstruction exists in the lower urinary tract. This can be done by inserting a catheter into the bladder. Unless the cause of renal failure is known, investigation of the upper urinary tract is obligatory. Some individuals may have only one functioning kidney. Bear in mind that ten per cent of calculi do not visualize. Bilateral ureteral obstruction from uric acid crystals or stones may occur during the treatment of gout with uricosuric agents. This may occur in the treatment of leukemia and lymphomas with alkylating agents due to obstruction by uric stones resulting from tissue destruction. Bilateral ureteral obstruction may occur in carcinoma of the bladder, cervix, prostate or rectum.

Treatment

Mannitol 25 per cent (100cc in 5 min.) may arrest tubular necrosis if given soon enough. Mannitol is effective only when dehydration and hypotension have been corrected. A urine output in excess of 200cc in 30 minutes is a positive response. If this is effective ten per cent mannitol should be given at a rate that will produce 1-2cc of urine per minute. This should be continued 24-48

hours. The urine output must be replaced. One half the replacement should be normal saline. If diuresis does not occur it is likely that tubular necrosis has occurred. There will then be three phases through which the patient will proceed—oliguria, early diuresis and late diuresis.

Oliguric Phase

This lasts 7-21 days. It is characterized by symptoms of uremia and electrolyte imbalance.

1. *Water* The excessive intake of fluid will lead to congestive heart failure and pulmonary edema. It is better to err on the insufficient side. The estimated insensible fluid loss (perspiration and respiration) by a 70kg. adult at bedrest with normal temperature is 1000cc per day. Preformed water and water or oxidation of body fat and protein should amount to 500cc per day, leaving a water deficit of 500cc. The remaining 500cc is given I. V. in the form of 50 per cent glucose solution. To this are added 15 units of insulin, 10ml. of heparin (to prevent thrombosis) and an ampule of vitamins B & C. With potassium intoxication the insulin may be increased to one unit for each three grams of glucose. Additional 5-10 per cent glucose in water and/or saline is given in sufficient amounts to replace the urinary output, gastric suction or diarrhea. Accurate daily weights should be kept. A weight loss of one-half to one pound per day indicates correct fluid balance. The patient should never gain weight. If adequate replacement therapy is promptly instituted many oliguric patients (due to shock) will recover rapidly with little evidence of renal damage. When oliguria persists after circulatory dynamics have been restored to normal and dehydration overcome, great care must be exercised to prevent overhydration. Each day an amount of fluid equal to the preceding day's urine volume is given intravenously.

2. *Calories* The administration of dextrose will eliminate ketosis and decrease endogenous protein catabolism. Thus the rate of accumulation of sulphate, phosphate, potassium and urea will be decreased. Glucose in excess of 100 grams per day has a profound protein sparing effect and further augments the metabolism of fats and fatty acids. Fifty per cent glucose I. V. suits the purpose. Any food ingested must be free of protein and potassium. Hard candies called "sour balls" furnish calories and aid oral hygiene by their abrasive action and by lowering the oral pH, thereby tending to lessen stomatitis and increase saliva production.

3. *Electrolytes, acidosis and nitrogen retention* Electrolyte loss in the oliguric phase is minimal so they must be administered cautiously. The low serum sodium found in uremia is due to a shift of sodium from the serum and extra-cellular space into the cells rather than an actual loss. Low serum Na is often due to iatrogenic overhydration. The latter is corrected by rigid fluid intake. No treatment is required for the former. Concentrated electrolyte solutions may be required when acidosis becomes severe (CO_2 combining power below 12MEQ/L). 100cc of one molar sodium lactate is effective. Correction of acidosis can be harmful in that administration of sodium lactate increases extra-cellular sodium with increase in extracellular fluid and may result in edema. This must contain 1-2 grams of calcium gluconate to prevent tetany. Alkaline salts may cause tetany by reduction of the concentration of ionic calcium. If blood is *lost*, blood should be given. If blood is not available give isotonic saline instead of dextrose in water since the former remains extra-cellular and thus tends temporarily to replace plasma as well as interstitial volume while dextrose in water is distributed largely intracellularly as soon as the dextrose has been metabolized. In giving blood the clinical condition of the patient, appearance, pulse, blood pressure, etc.—is a better guide to the need for blood than is the hemoglobin or hematocrit. Both of these values may remain unchanged in spite of massive hemorrhage, since an appreciable period of time is required for hemodilution to occur.

In mercury poisoning, diarrhea and vomit-

ing may be so extensive that many liters of isotonic fluid will be required to make up the deficit.

Testosterone propionate or Nilevar (Searle) 50mg. I. M. every other day will reduce protein catabolism. In addition to the production of 500cc of water per day, tissue breakdown releases potassium, phosphates, sulfates, organic acids, magnesium and urea.

Serum potassium elevation results from potassium release from depleted glycogen stores, red blood cell destruction, protein and fat catabolism tissue destruction, and shift of potassium out of the cells caused by metabolic acidosis.

Potassium intoxication is an expected sequel to renal failure. At the present time, the artificial kidney is not often required.

Treatment of Hyperkalemia

(a) The metabolism of I. V. 50 per cent glucose with insulin forces potassium back into the cells.

(b) As a temporary emergency measure 100cc of one molar lactate or 3-5 per cent sodium chloride solution is effective I. V.

(c) Nasogastric suction will remove potassium and hydrogen ions.

(d) The cation exchange resin sodium polystyrene sulfonate (Kayexalate, Winthrop) is effective in removing potassium, given 10-25gms in 100cc of water orally or as a retention enema.

(e) Sorbital 70 per cent (10-20cc every 6-12h) orally produces osmotic diarrhea removing large amounts of potassium and water and facilitating the passage of resin through the intestines.

The electrocardiogram is valuable in detecting myocardial conduction changes due to hyperkalemia.

4. Tetany is rarely a problem in the management of acute renal failure, since the concomitant acidosis tends to protect the patient from overt manifestations. The effect is presumably due to the fact that increased acidity leads to increased concentration of ionic calcium. It may also be due to minor increase in extracellular magnesium encountered in anuria that serves to diminish central nervous system excitability.

5. Infection is common in the uremia patient. Streptomycin, kanamycin, tetracycline and polymyxin are excreted by the kidney and should not be given to uremic patients. Penicillin, erythromycin, chlortetracycline, and chloramphenicol are metabolized.

6. Anemia is due to increased destruction and decreased production of red blood cells. Transfusion of fresh packed red cells is indicated when the hematocrit falls below 20mg per cent. Plasma should not be given because of its high potassium content and excess fluid volume.

In cases of poisoning: (1) try to remove the toxin from the body; (2) administer specific antidotes; (3) use measures to overcome circulatory shock and replace the loss of body fluids.

Specific antidotes:

(1) Dimercaprol (Bal) in mercury and arsenic poison

(2) Methylene blue in methemoglobinemia

(3) Nitrates and thiosulfate in cyanide poisoning

(4) Central nervous stimulants in barbiturate poisoning

(5) Depressants in strychnine poisoning

(6) Allyl-nor-morphine in opiate poisoning

Early Diuretic Phase

In spite of the large urinary output there may be little change in the uremic state because the tubular epithelium has not recovered sufficiently to perform its function of reabsorption. More patients die in the diuretic phase than the oliguric phase, due to the tremendous loss of fluid and electrolytes.

Water and sodium lost in the urine must be measured and replaced. Due to loss of potassium it is important to observe the clinical and the electrocardiographic course as well as serum potassium levels.

Exchange transfusions have been used in the treatment of acute renal failure primarily in France and Italy. They are not very practical because very little urea and practically no potassium is removed.

7. *Dialysis*

Intestinal lavage, peritoneal lavage and external dialysis can be considered as having the same basic features. Intestinal lavage is complicated by the active absorption and excretion of electrolytes and water by the intestinal mucosa. A hypertonic solution of sucrose and sodium sulfate is administered into the small bowel via one tube and recovered by a second tube or the lumen of a double lumen tube. A simple method is that of purging with hypertonic magnesium or sodium sulfate given orally. This may help early in acute renal failure when the patient has been given too much fluid.

The artificial kidney and peritoneal dialysis may be necessary to relieve the symptoms of uremia. Dialysis is an adjunct to good management of renal failure and should be reserved for patients with a reversible form of uremia. Dialysis is highly effective in the patient with sudden, severe hyperkalemia.

Peritoneal Lavage

The composition of the fluid should resemble extracellular fluid except that for rapid removal of potassium a lower concentration of the ion may be selected. Phosphates and sulfates can be omitted since these are always in excess in uremia and their rapid removal does no harm. Calcium should be added because this ion is usually low in uremia.

By adjusting the electrolyte and glucose content of the lavaging fluid and the time during which this is allowed to remain in the abdominal cavity, it is thus possible to adjust the volume of the extracellular fluid as well as its composition. The procedure can be used, moreover, with the facilities available in any hospital and without technical difficulty.

In intermittent peritoneal lavage the lavaging fluid is introduced and removed through a small *polyethylene* medical tube, which causes no tissue reaction and does not adhere to the omentum. Tubing of an internal diameter of 0.115 and an outside diameter of 0.147 inch is satisfactory. A series of small holes may be placed in the end of the tube by means of a heated needle and a suitable length of the material (approximately 12 to 18 inches) is kept ready for use by immersion in a bland germicidal solution. This tube is introduced into the peritoneal cavity through an ordinary paracentesis trocar. After a local anesthetic is injected under the skin, the trocar is inserted either in the mid-line below the umbilicus or laterally along the transversalis muscles. After removing the stylet from the trocar, the polyethylene tubing is introduced and directed into the pelvis. Care should be taken not to introduce it so far that it curls back upon itself; its end should occupy the lowermost point in the pelvic gutter.

Ten per cent glucose in water exerts the osmotic force necessary for preventing absorption of the fluid during the one and one-half to two hours that it remains in the abdomen. If it is necessary to remove fluid from the patient, a more concentrated glucose solution (5 to 10 per cent) is used. This is prepared by adding the necessary amount of 50 per cent glucose. If it is desired to hydrate the patient, less glucose (1 gram per liter) is used. In addition to the electrolytes and glucose, 100,000 units of crystalline penicillin or 25 mgms. of terramycin hydrochloride are added to each liter as a prophylactic against infection.

The lavaging fluid is allowed to flow into the body cavity by gravity. Two or three liters of fluid are introduced at one time, the amount being such as to cause no appreciable

discomfort to the patient by distention of the abdomen. In children, correspondingly smaller amounts (0.5 to 1.5 liters) are used, depending on their size.

The solution is allowed to remain in the peritoneal cavity for one and one-half hours to permit its entering into an equilibrium with the blood. The polyethylene tube is then connected through a sterile rubber tube with a bottle placed on the floor beside the bed of the patient and the fluid allowed to siphon off. In cases where absorption of fluid has occurred, this may be recovered by increasing the glucose content of the solution (to five per cent or more) and withdrawing it after about an hour or less. By using such high concentration of glucose, fluid may be rapidly withdrawn from the body in cases of pulmonary or systemic *edema.* In patients with *hyperpotassemia,* a solution from which potassium chloride has been omitted is used.

For most purposes six to 12 exchanges with two to three liters at two hourly intervals suffice to restore a sufficiently normal state to permit resumption of the conservation regime described earlier. By allowing the polyethylene tube to remain in the peritoneal cavity, one may resort to the use of peritoneal lavage again should this become necessary later.

Summary

The causes of acute renal failure have been discussed. Mannitol 25 per cent I. V. may arrest tubular necrosis if given soon enough. This drug is effective only when dehydration and hypotension have been corrected. If tubular necrosis does occur the patient will go through three phases, i. e., oliguria, early diuresis and late diuresis. The treatment of the patient in these three phases has been discussed. The specific treatment of hyperkalemia has been covered also. Peritoneal lavage is a rather uncomplicated, effective method of treating the patient with acute renal failure especially, when sudden, severe, hyperkalemia occurs.

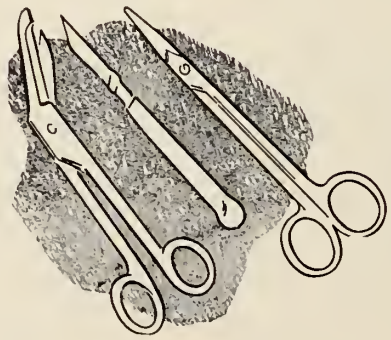
References

1. Grollman Arthur: Acute Renal Failure, 1954.

2. O'Brien, T. F., Teschan, P. E., and Baxter, C. R. Hemodialysis for Acute Renal Failure.

3. U. S. Armed Forces Medical Journal 11: 991-1000, 1960.

4. Current Therapy, Conn 1964. Acute Renal Failure, Meyer, Robert.





"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests: they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.



LOMOTIL *Pharmacologic Activity*

The significant pharmacologic actions of Lomotil are summarized as follows:

Evidence indicates that Lomotil acts directly on the intestinal musculature to inhibit excess peristalsis.

Lomotil is not known to inhibit nonpropulsive intestinal movements.

Roentgenograms demonstrate that this activity occurs within two hours after oral administration and persists for at least six hours.

Comparative studies in the rat show Lomotil to be more effective in inhibiting fecal excretion than either codeine or morphine.

Analgesic, anticholinergic, mydriatic and gastric secretory effects have not been significant.

Reduction of propulsive motility with Lomotil relieves spasm and cramping, allows physiologic absorption of fluid and reduces frequency of evacuations to provide prompt, symptomatic control of virtually all diarrheas.

LOMOTIL®

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)

atropine sulfate 0.025 mg.

tablets • liquid

slows propulsion



relieves distress



stops diarrhea



Precautions: Lomotil is an exempt narcotic preparation of very low addictive potential: more than three million prescriptions have now been written for Lomotil. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, *given in divided doses,* until diarrhea is controlled, are:

Children:

3 to 6 months—3 mg. (½ tsp.* t.i.d.)
6 to 12 months—4 mg. (½ tsp. q.i.d.)
1 to 2 years—5 mg. (½ tsp. 5 times daily)
2 to 5 years—6 mg. (1 tsp. t.i.d.)
5 to 8 years—8 mg. (1 tsp. q.i.d.)
8 to 12 years—10 mg. (1 tsp. 5 times daily)

Adults:

20 mg. (2 tsp. 5 times daily or
2 tablets 4 times daily)

**Based on 4 cc. per teaspoonful.*

Maintenance dosage may be as low as one fourth the therapeutic dose.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE *Research in the Service of Medicine*

Alabama Department of Public Health

Death of A Mosquito

By Raymond L. White, M. D., Director

Division of Environmental Medicine and Medical Services

American Medical Association

The American Medical Association and the Public Health Service are joining forces in eradicating a disease vector, the Aedes aegypti mosquito, which threatens a large area of the United States with serious disease. Our lack of action could endanger countries where the Aedes aegypti has already been eliminated.

The United States has been somewhat delinquent in this health obligation to our hemispheric neighbors; and the current Aedes aegypti eradication program is a real step forward. United States scientists discovered that yellow fever is transmitted by the Aedes aegypti mosquito; United States scientists using United States money helped to rid a large part of Central and South America and the Caribbean of this disease vector; yet there has not been a large scale attack on this vector in our own country.

In 1947 the Pan American Health Organization resolved that there should be a hemisphere-wide eradication program against the Aedes aegypti mosquito. The majority of member nations of this organization began eradication programs at that time, and many achieved satisfactory results. The directing council of the Pan American Health Organization again resolved in 1961 that all nations in the western hemisphere should begin eradication programs. The United States signed this resolution. In December 1962 the American Medical Association called attention to the problem and pointed out the public health threat to our southern states. It also emphasized our international obligation.

Congress supported this program and appropriated funds for a Survey and Eradication Program. The Public Health Service, through the Communicable Disease Center, has established an Aedes aegypti Eradication Branch to implement the program through the health departments of the states involved.

In December 1964 the House of Delegates of the American Medical Association approved a report of the Board of Trustees relating to Aedes aegypti mosquito eradication.

This report included the following paragraphs:

> "The one remaining stronghold of Aedes aegypti is a 300,000 square mile area involving the nine states from South Carolina to Texas, and Puerto Rico and the Virgin Islands. So long as these mosquitoes may become infected by persons infected with the jungle yellow fever virus of South America, epidemics of yellow fever are possible in the United States.
>
> "The Board believes that the American Medical Association should cooperate with the Communicable Disease Center of the Public Health Service in promoting eradication of the Aedes aegypti mosquito, and recommends that the House of Delegates encourage the state and local medical societies of the states and territories concerned, and the physicians practicing therein, to cooperate in every possible way to insure complete eradication of the Aedes aegypti mosquito from the American hemisphere."

It is quite obvious that the eradication of an insect vector is a job which requires the special skills of the epidemiologist, the public health engineer, the entomologist, the vector control personnel, the biologist and others who participate in the environmental control activities of the state public health departments. Even so, human health is involved and since both yellow fever and dengue are transmitted by this mosquito, the eradication program is of interest to physicians. Physicians, however, particularly those in private practice, are hardly in a position to join into the actual administration of eradication procedures. Yet, they have a definite part to play in this rather different public health program.

The role of the physician is one of education and encouragement of public support. Many patients may become confused or alarmed by public announcements about the development of eradication activities. Many will come to their physician with questions regarding the advisability of supporting this program. They will have questions about the health hazards of the chemicals used, about possible changes in the balance of nature, and many other problems. Particularly, the public needs information on how to destroy or remove the innumerable small collections of water found in an urban environment which provides the breeding places for their particular mosquito. It is necessary that the physician be well acquainted with the procedures used and their effect upon the community. Having this information, physicians can better support eradication activities and encourage patients to cooperate.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

June 7, 1965

Examinations for intestinal parasites	1,698
Typhoid cultures (blood, feces, urine and other)	254
Examinations for malaria	0
Examinations for gonococci	1,866
Serologic tests for syphhilis (blood and spinal fluid)	26,801
Darkfield examinations	0
Agglutination tests	11
Examinations for diphtheria bacilli and vincent's	7
Examinations for Negri bodies (smears and animal inoculation)	240
Complement Fixation	177
Water examination	2,445
Milk and dairy products examination	3,885
Examination for tubercule bacilli	3,920
Miscellaneous examination	7,713
Total	49,017

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

Current Morbidity Statistics

1965

	April	May	*E. E. May
Tuberculosis	109	146	173
Syphilis	175	195	129
Gonorrhea	304	284	327
Chancroid	1	1	2
Typhoid fever	1	1	2
Undulant fever	0	0	0
Amebic dysentery	3	5	2
Scarlet fever & strep. throat	176	200	77
Diphtheria	6	0	1
Whooping cough	3	5	23
Meningitis	13	6	9
Tularemia	0	0	0
Tetanus	1	2	2
Poliomyelitis	0	0	1
Encephalitis	0	1	1
Smallpox	0	0	0
Measles	531	276	1,105
Chickenpox	144	79	171
Mumps	92	101	80
Infectious hepatitis	36	38	46
Typhus fever	0	1	0
Malaria	0	0	0
Cancer	603	953	728
Pellagra	0	0	0
Rheumatic fever	12	13	17
Rheumatic heart	15	30	31
Influenza	674	133	90
Pneumonia	439	326	218
Rabies—Human cases	0	0	0
Pos. animal heads	0	0	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

Hygroton®

brand of chlorthalidone

the long-acting diuretic

Indications: Many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

*Dorhout Mees,E.J.,and Geyskes, G.G.: Acta med.scandinav. 175:703,1964.

Photos: A 59-year-old woman with hypertensive cardiovascular disease and edema resistant to low-salt diet and bed rest. The patient lost 8½ lbs. in one week with a single tablet daily of Hygroton, brand of chlorthalidone.

Geigy Pharmaceuticals
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good riddance

Hygroton, brand of chlorthalidone, gets rid of edema efficiently. Your edematous patients will generally need far fewer tablets than with most diuretics. And they'll generally save more on prescription costs. One tablet a day is a popular dosage. So is one tablet every other day. You may even find half a tablet three times a week does the job. No other diuretic works as long. And none has as much natruretic activity per tablet.* For good riddance of edema with the least number of tablets, prescribe Hygroton, brand of chlorthalidone.

Hygroton® brand of chlorthalidone

Geigy

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

CURRENT MORBIDITY STATISTICS

1965

	March	April	*E. E. April
Tuberculosis	118	109	129
Syphilis	171	175	137
Gonorrhea	236	304	294
Chancroid	2	1	4
Typhoid fever	0	1	0
Undulant fever	1	0	0
Amebic dysentery	5	3	5
Scarlet fever & strep. throat	283	176	151
Diphtheria	1	6	1
Whooping cough	3	3	11
Meningitis	3	13	6
Tularemia	0	0	1
Tetanus	1	1	1
Poliomyelitis	0	0	0
Encephalitis	0	0	1
Smallpox	0	0	0
Measles	569	531	502
Chickenpox	193	144	243
Mumps	40	92	192
Infectious hepatitis	31	36	37
Typhus fever	0	0	0
Malaria	0	0	0
Cancer	1,032	603	662
Pellagra	1	0	0
Rheumatic fever	14	12	13
Rheumatic heart	22	15	25
Influenza	20,904	674	935
Pneumonia	505	439	260
Rabies—Human cases	0	0	0
Pos. animal heads	1	0	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

April, 1965

Examinations for intestinal parasites	2,209
Typhoid cultures (blood, feces, urine and other)	221
Examinations for malaria	4
Examinations for gonococci	1,945
Serologic tests for syphilis (blood and spinal fluid)	25,738
Darkfield Examinations	3
Agglutination tests	19
Examinations for diphtheria bacilli and vincent's	37
Examinations for Negri bodies (smears and animal inoculations)	296
Complement Fixation	78
Water Examinations	2,339
Milk and dairy products examinations	3,914
Examinations for tubercle bacilli	4,037
Miscellaneous examinations	7,372
Total	48,212

BUREAU OF VITAL STATISTICS

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA, 1964

Ralph W. Roberts, M. S., Director

Live Births / Deaths / Causes of Death	Number Recorded			Rates*		
	Prov. 1964	Final 1963	Average 1958-1962	Prov. 1964	Final 1963	Average 1958-1962
Live Births	75,830	75,522	80,502	22.3	22.4	24.6
Deaths	31,330	31,849	29,611	9.2	9.4	9.0
Fetal Deaths	1,554	1,546	1,723	20.1	20.1	21.0
Infant Deaths—						
under one month	1,565	1,619	1,715	20.6	21.4	21.3
under one year	2,350	2,440	2,598	31.0	31.8	32.3
Maternal Deaths	54	63	62	7.0	7.5	7.5
Causes of Death						
Tuberculosis, 001-019	246	270	299	7.2	8.0	9.1
Syphilis, 020-029	45	39	60	1.3	1.2	1.8
Dysentery, 045-048	9	8	13	0.3	0.2	0.4
Diphtheria, 055	3	4	5	0.1	0.1	0.2
Whooping cough, 056	8	2	8	0.2	0.1	0.2
Meningococcal infections, 057	23	17	18	0.7	0.5	0.6
Poliomyelitis, 080, 081	3	6	5	0.1	0.2	0.2
Measles, 085	13	4	12	0.4	0.1	0.4
Malignant neoplasms, 140-205	4,198	4,037	3,807	123.3	119.7	116.4
Diabetes mellitus, 260	450	460	432	13.2	13.6	13.2
Pellagra, 281	2	4	7	0.1	0.1	0.2
Vascular lesions of central nervous system, 330-334	4,367	4,427	4,116	128.2	131.3	125.8
Rheumatic fever, 400-402	16	26	26	0.5	0.8	0.8
Diseases of the heart, 410-443	10,377	10,550	9,862	304.8	312.9	301.4
Hypertension with heart disease, 440-443	1,433	1,570	1,768	42.1	46.6	54.0
Diseases of the arteries, 450-456	697	702	679	20.5	20.8	20.8
Influenza, 480-483	53	278	193	1.6	8.2	5.9
Pneumonia, all forms, 490-493	910	1,115	872	26.7	33.0	26.6
Bronchitis, 500-502	60	66	64	1.8	2.0	2.0
Appendicitis, 550-553	39	38	30	1.1	1.1	0.9
Intestinal obstruction and hernia, 560, 561, 570	153	156	144	4.5	9.6	4.4
Gastro-enteritis and colitis, under 2, 571.0, 764	116	112	139	3.4	3.3	4.2
Cirrhosis of liver, 581	206	209	192	6.0	6.2	5.9
Diseases of pregnancy and childbirth, 640-689	54	63	62	7.0	8.2	7.5
Congenital malformations, 750-759	398	397	388	5.2	5.3	4.8
Immaturity at birth, 774-776	430	513	565	5.7	6.8	7.0
Accidents, total, 800-962	2,189	2,208	2,012	64.3	65.5	61.5
Motor vehicle accidents, 810-835, 960	1,060	1,058	920	31.1	31.4	28.1
All other defined causes	4,569	4,594	4,393	134.2	136.2	134.3
Ill-defined and unknown causes, 780-793, 795	1,696	1,544	1,208	49.8	45.8	36.9

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

BUREAU OF VITAL STATISTICS
PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA,

MARCH, 1965

Ralph W. Roberts, M. S., Director

Live Births / Deaths / Causes of Death	Number Registered During March 1965			Rates* (Annual Basis)		
	Total	White	Non-White	1965	1964	1963
Live Births	5,975	3,774	2,201	20.2	20.6	22.1
Deaths	3,135	2,030	1,105	10.6	9.6	11.6
Fetal Deaths	123	57	66	20.2	20.8	19.1
Infant Deaths—						
under one month	110	62	48	18.4	20.4	17.7
under one year	201	93	108	33.6	34.0	30.0
Maternal Deaths	4		4	6.6	5.0	10.9
Causes of Death						
Tuberculosis, 001-019	27	15	12	9.1	8.7	11.2
Syphilis, 020-029	7	4	3	2.4	1.7	1.0
Dysentery, 045-048						
Diphtheria, 055						
Whooping cough, 056	1		1	0.3		
Meningococcal infections, 057	3	2	1	1.0	0.7	0.3
Poliomyelitis, 080, 081	1	1		0.3		0.3
Measles, 085	2		2	0.7	0.7	
Malignant neoplasms, 140-205	374	270	104	126.5	127.6	124.0
Diabetes mellitus, 260	64	35	29	21.6	12.8	17.5
Pellagra, 281	1	1		0.3		0.7
Vascular lesions of central nervous system, 330-334	467	294	173	158.0	136.6	161.0
Rheumatic fever, 400-402	1		1	0.3	0.3	1.0
Diseases of the heart, 410-443	994	724	270	336.3	311.4	351.3
Hypertension with heart disease, 440-443	124	52	72	42.0	43.7	51.0
Diseases of the arteries, 450-456	78	52	26	26.4	19.8	22.3
Influenza, 480-483	40	31	9	13.5	2.8	48.9
Pneumonia, all forms, 490-493	160	83	77	54.1	39.2	74.7
Bronchitis, 500-502	12	9	3	4.1	2.1	3.5
Appendicitis, 550-553	1	1		0.3	1.4	0.7
Intestinal obstruction and hernia, 560, 561, 570	15	11	4	5.1	5.2	2.8
Gastro-enteritis and colitis, under 2, 571.0, 764	8	1	7	2.7	2.8	1.7
Cirrhosis of liver, 581	21	15	6	7.1	7.3	5.6
Diseases of pregnancy and childbirth, 640-689	4		4	6.6	5.0	10.9
Congenital malformations, 750-759	30	26	4	5.0	4.4	4.1
Immaturity at birth, 774-776	55	34	21	9.2	5.7	5.5
Accidents, total, 800-962	194	126	68	65.6	61.0	70.9
Motor vehicle accidents, 810-835, 960	75	52	23	25.4	27.4	25.5
All other defined causes	390	218	172	131.9	136.6	161.7
Ill-defined and unknown causes, 780-793, 795	185	77	108	62.6	63.8	80.0

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

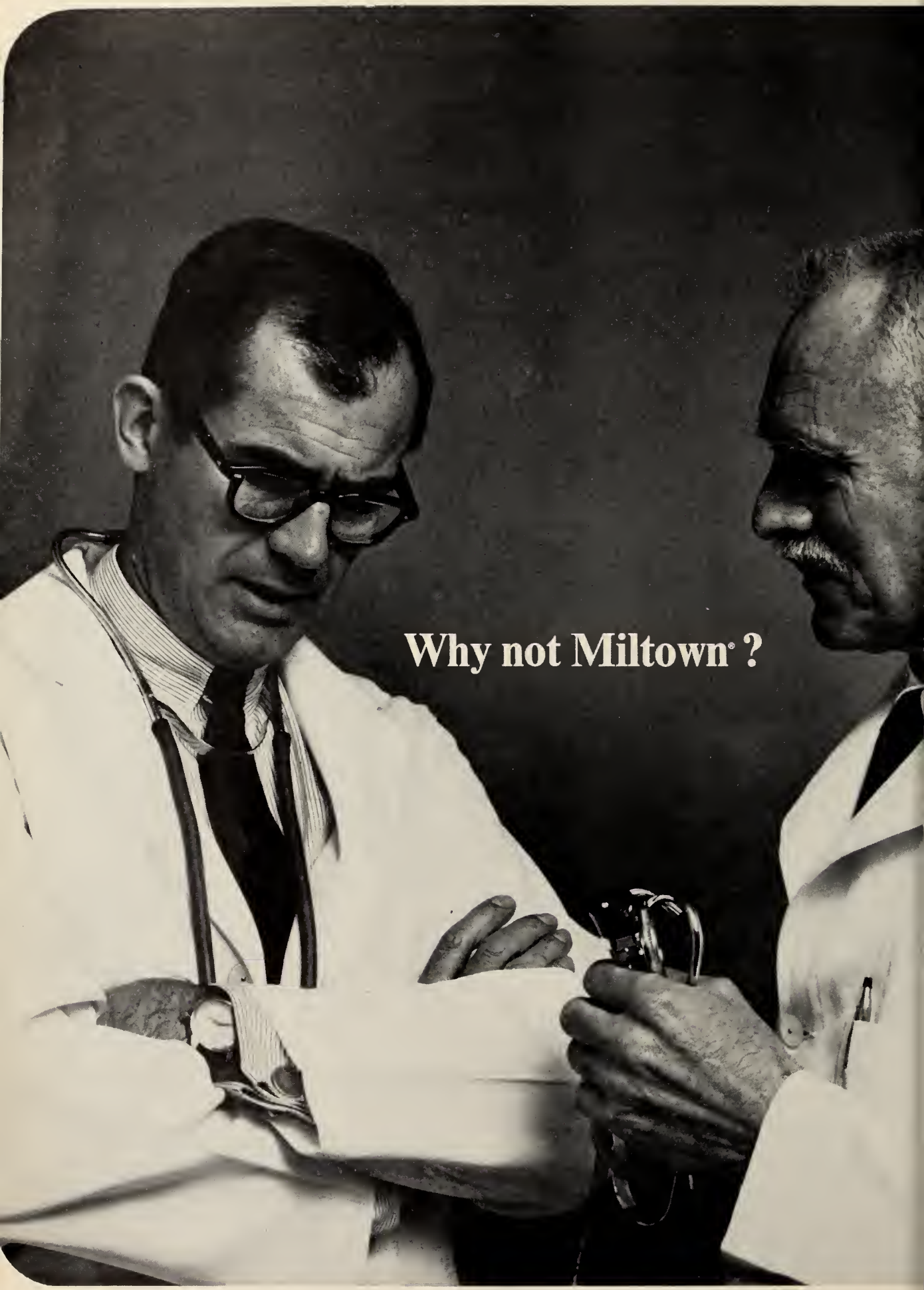
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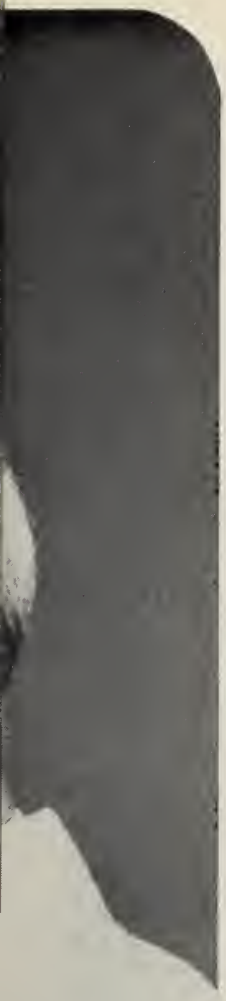
FEBRUARY, 1965

Ralph W. Roberts, M. S., Director

Live Births / Deaths / Causes of Death	Number Registered During February 1965			Rates* (Annual Basis)		
	Total	White	Non-White	1965	1964	1963
Live Births	5,370	3,350	2,020	20.1	22.6	22.4
Deaths	2,554	1,650	904	9.6	9.4	11.0
Fetal Deaths	107	37	70	19.5	14.8	17.5
Infant Deaths—						
under one month	101	47	54	18.8	19.8	20.4
under one year	194	81	113	36.1	34.5	40.3
Maternal Deaths	3	1	2	5.5	9.7	11.9
Causes of Death						
Tuberculosis, 001-019	12	7	5	4.5	7.4	9.3
Syphilis, 020-029	5	1	4	1.9	1.5	1.9
Dysentery, 045-048	2	2		0.7		
Diphtheria, 055						
Whooping cough, 056	2		2	0.7		
Meningococcal infections, 057					0.7	0.4
Poliomyelitis, 080, 081					0.4	
Measles, 085	4		4	1.5		0.4
Malignant neoplasms, 140-205	299	223	76	112.0	101.9	128.0
Diabetes mellitus, 260	51	28	23	19.1	13.3	17.8
Pellagra, 281						
Vascular lesions of central nervous system, 330-334	336	214	122	125.8	136.4	150.0
Rheumatic fever, 400-402	1	1		0.4	0.4	0.8
Diseases of the heart, 410-443	851	639	212	318.8	329.9	359.9
Hypertension with heart disease, 440-443	96	44	52	36.0	48.6	54.9
Diseases of the arteries, 450-456	55	30	25	20.6	20.8	22.4
Influenza, 480-483	18	12	6	6.7	3.0	20.9
Pneumonia, all forms, 490-493	101	50	51	37.8	35.2	57.2
Bronchitis, 500-502	11	10	1	4.1	2.2	3.9
Appendicitis, 550-553	1	1		0.4	1.5	0.8
Intestinal obstruction and hernia, 560, 561, 570	10	8	2	3.7	4.8	7.3
Gastro-enteritis and colitis, under 2, 571.0, 764	14	2	12	5.2	6.3	5.0
Cirrhosis of liver, 581	11	9	2	4.1	4.8	6.6
Diseases of pregnancy and childbirth, 640-689	3	1	2	5.5	9.7	11.9
Congenital malformations, 750-759	34	24	10	6.3	5.1	5.9
Immaturity at birth, 774-776	22	9	13	4.1	5.1	5.0
Accidents, total, 800-962	190	127	63	71.2	52.3	59.9
Motor vehicle accidents, 810-835, 960	98	74	24	36.7	18.2	20.5
All other defined causes	348	205	143	130.3	133.1	150.4
Ill-defined and unknown causes, 780-793, 795	173	47	126	64.8	60.0	73.5

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population


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There are few "nots" in Miltown therapy

■ **Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.**

■ **The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.**

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

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The Woman's Auxiliary



HELP WANTED---PHYSICIAN

The Woman's Auxiliary to The Medical Association of the State of Alabama and the Health Careers Council of Alabama request YOUR assistance, as a Physician, to campaign in YOUR community for one (1) student to enter one of the paramedical schools this September, 1965. This student would be in addition to those individuals who have already enrolled in schools for admission this fall.

Last year in the Alabama Schools of Nursing alone there were 416 student vacancies. With the critical shortage in health personnel in this state and in view of the high attrition rate, our schools should already be bulging at the seams in order to produce the minimum number of health personnel needed.

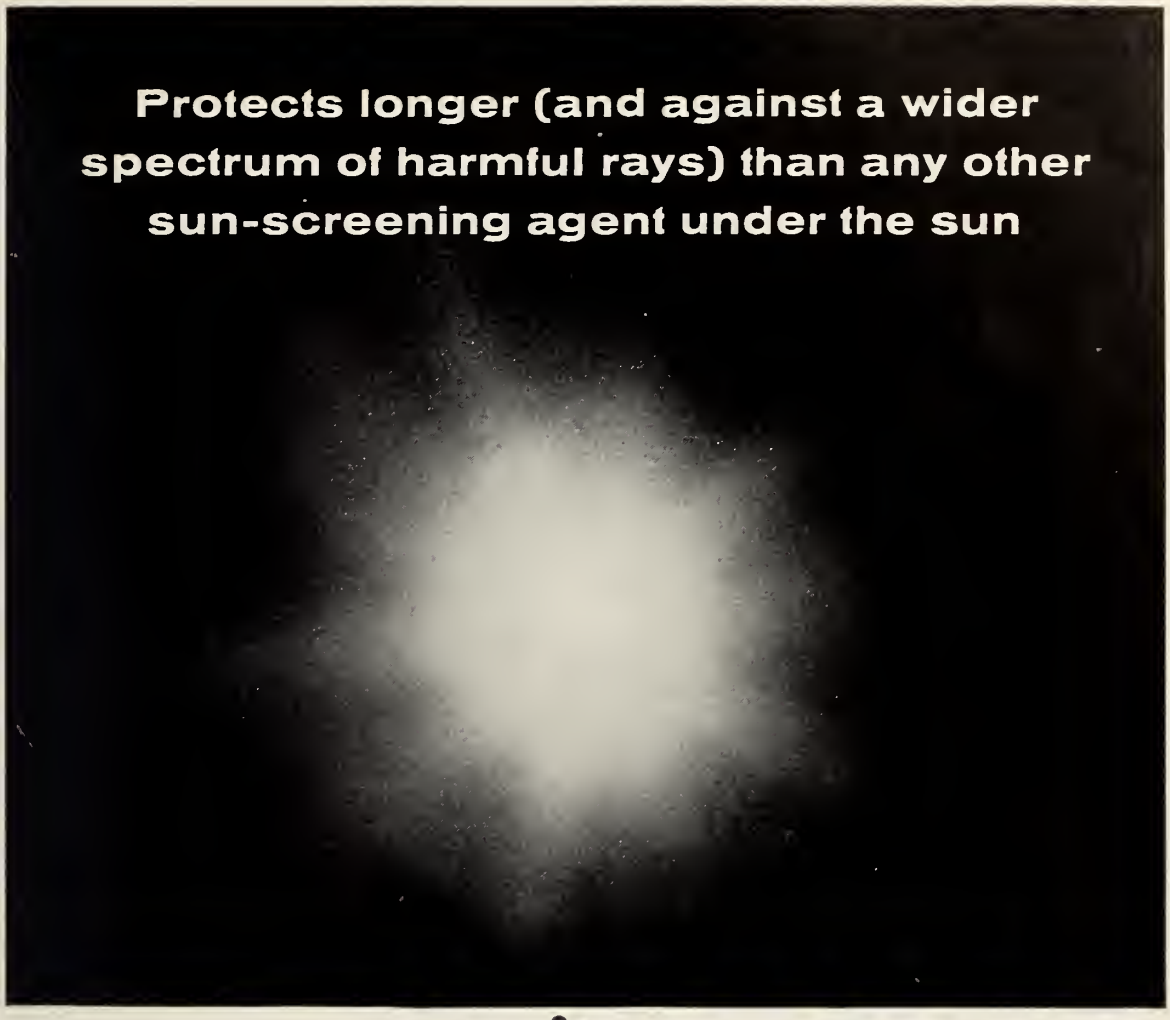
No obstacle should prevent a youngster who is interested in a career in one of the health professions from entering school this fall. **FIND ONE (1) STUDENT. BE SURE HE GETS ENROLLED IN SCHOOL.** This may mean that you will need to help him find financial assistance—It may mean that a particular school may need to be persuaded to accept a student after applications are closed.

ONE ADDITIONAL STUDENT FROM YOUR COMMUNITY IS A CHALLENGE WE HOPE YOU WILL ACCEPT! LET'S WORK TOGETHER TO ATTAIN THIS GOAL!

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Mrs. James F. Crenshaw

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around the state

MEDICAL ASSISTANTS SEMINAR

SATURDAY, JULY 31, 1965

1:00 p. m.-2:00 p. m.

Registration, Lobby, University Center

Presiding: Mrs. Marie S. Swindle, Past President, Alabama Medical Assistants Association and Seminar Co-Chairman Tuscaloosa

2:00 p. m.

Welcome: Mr. R. W. Springfield
Director, Montgomery Center

Response: Mrs. Mildred Channell, Past Recording Secretary, Alabama Medical Assistants Assn., Decatur

2:15-2:45 p. m.

"The Medical Assistant—Her Doctor's Public Relations Representative"—Mrs. Ruth Reynolds, Past President, Alabama Medical Assistants Association, Gadsden

2:45-3:30 p. m.

"Your Major Responsibility—Office Management"—Dr. Wilson T. Ashby, Professor and Head, Department of Secretarial Administration, University

3:30 p. m.

Break

4:00-4:30 p. m.

"Health Care for the Elderly"—Mr. W. V. Wallace, Executive Secretary, Medical Association of the State of Alabama, Montgomery

4:30-5:30 p. m.

"A Responsibility—Writing as a Medium of Communication"—Dr. Wilson T. Ashby, University of Alabama

7:00 p. m.

Dinner: Jefferson Davis Hotel

Presiding: Mrs. Frances Spates, President, Alabama Medical Assistants Association, Vincent

Invocation: Mrs. Majorie Peavy, Past Vice President, Alabama Medical Assistants Association, Mobile

Introduction: Dr. Ira L. Myers, State Health Officer, Montgomery

"The Future of Medicine in Alabama"—Dr. James G. Donald, President, Medical Association of the State of Alabama, Mobile

SUNDAY, AUGUST 1, 1965

Presiding: Mrs. Vivian M. Head, President-Elect, Alabama Medical Assistants Association, Anniston

9:00-9:30 a. m.

"An Introduction to Pathology"—Dr. Walker Sorrell, Montgomery

9:30-10:00 a. m.

"How to Deal With Cardiac Emergencies" —Dr. William W. Tisdale, Jr., Montgomery

10:00 a. m.

Break

10:15-11:00 a. m.

"Handling Past Due Accounts"

Moderator: Mrs. Ann Taylor, Past Vice President, Alabama Medical Assistants Association, Tuscaloosa

Mr. L. Barry Holloway, President, Associated Credit Bureaus of Alabama, Huntsville

Mrs. Juliette Pearce, Collection Department, St. Margaret's Hospital, Montgomery

Mrs. Ethel Lee Redfern, Corresponding Secretary, Alabama Medical Assistants Association, Birmingham

11:00 a. m.-12:15 p. m.

"Are You Communicating Verbally"—Mrs. Anabel D. Hagood, Professor and Director of Forensics, University of Alabama

12:30 p. m.

Luncheon: Jefferson Davis Hotel

Presiding: Mrs. Martha Foote, Seminar Chairman, Birmingham

Invocation: Mrs. Pearl Foote, President, Morgan County Chapter, Decatur

Introduction: Mrs. Opal G. Nixon, Past President, Alabama Medical Association, Mobile

"Health Mobilization"—Mr. Max G. Cain, Chief, Health Mobilization Section, Hospital Planning Division, Alabama Department of Public Health, Montgomery

Presiding: Mrs. Nelda Johnson, Past President, Madison County Chapter, Huntsville

2:15-2:45 p. m.

"Emotionally Induced Illness"—Dr. Almond Ward, Montgomery

2:45-3:15 p. m.

"The Narcotics Problem"—Mr. Nordert Adamski, Federal Narcotic Agent, State of Alabama, Birmingham

3:15 p. m.

Break

3:30-4:00 p. m.

"Patients With Respiratory Conditions"—Dr. S. J. Selikoff, Montgomery

4:00-4:15 p. m.

Closing Remarks and Evaluation—Mr. Anyan A. Gordon, Director, Commerce Extension Services, University of Alabama

PLANNING COMMITTEE

Chairman: Mrs. Martha Foote, Birmingham
Co-Chairman: Mrs. Marie Swindle, Tuscaloosa

Tuscaloosa County: Mrs. Bessie Mae Davis, Mrs. Florence Edwards, Mrs. Mary Fleming, Mrs. Ann Taylor, Mrs. Eva Brooks

Jefferson County: Mrs. Matt Bainbridge, Mrs. Dora Brooks, Mrs. Edna Brantley, Miss Barbara Tubb, Mrs. Johnnie Wallace, Mrs. Dorothy Gorham

Mobile County: Miss Alice Gadilhe, Mrs. Marion Ziegelmeier, Mrs. Muriel Westfall, Mrs. Majorie Peavy, Mrs. Opal Dixon

Morgan County: Mrs. Della Hodges, Mrs. Viola Plabough, Mrs. Mildred Channell

Calhoun County: Miss Betty M. Jacks, Mrs. Vivian Head

Etowah County: Mrs. Mildred Johnson, Mrs. Ruth Reynolds

Medical Association of the State of Alabama: Mr. Bill Wallace, Dr. Theodore S. Cone, Dr. John H. Nelson

University of Alabama: Dr. Wilson Ashby, C. E. Adams, Robert W. Springfield, Dr. Margaret Klapper, Anyan A. Gordon

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revive interest... restore activity promptly with

Alertonic®

Three tablespoonfuls (45 cc.) contain:		
Pipradrol hydrochloride		2 mg.
Vitamin B_1 (thiamine hydrochloride)	(10 MDR*)	10 mg.
Vitamin B_2 (riboflavin)	(4 MDR*)	5 mg.
Vitamin B_6 (pyridoxine hydrochloride)		1 mg.
Nicotinamide	(5 MDR*)	50 mg.
Choline†		100 mg.
Inositol†		100 mg.
Calcium glycerophosphate	(2% MDR for calcium and phosphorus)	100 mg.
Cobalt (as chloride)		1 mg.
Manganese (as sulfate)		1 mg.
Magnesium (as acetate)		1 mg.
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Molybdenum (as ammonium molybdate)		1 mg.
Alcohol 15%		

*Multiple of adult Minimum Daily Requirement supplied
†Requirement in human nutrition not yet established

the need for a tonic knows no age Anyone can feel tired and "old" too soon. In such functional fatigue, Alertonic helps to lift mood, revive interest, restore purposeful activity promptly. Yet it contains no MAO inhibitors, no hormones. Alertonic is the effective formulation of a cerebral stimulant (pipradrol hydrochloride), alcohol, vitamins, and minerals ... available on prescription *only*. For common functional complaints (mild mood depression, tiredness); geriatric or convalescent patients, Rx one *tablespoonful* Alertonic *t.i.d.*, thirty minutes before meals. Contraindicated in agitated pre-psychotic patients, paranoia, or other patients in whom hyperexcitability, anxiety, chorea, or obsessive-compulsive states are present. Mild central stimulant side effects may occasionally occur.

Brochure with full product information available on request.

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NEW OFFICERS FOR ALABAMA HEART ASSOCIATION—Pictured here at the recent Annual Meeting of the Alabama Heart Association in Birmingham are newly elected and retiring officers of the Association. L. to R.: John Maples, Jr., Executive Vice President of Union Bank and Trust Company of Montgomery, re-elected as Treasurer; Dr. T. Joseph Reeves, Director of the Cardiovascular Division, Department of Medicine, Medical College of Alabama, elected as Chairman of the Board; Dr. E. Fred Campbell of Jackson Hospital, Montgomery, installed as President; and the retiring Chairman of the Board, Mr. Bob Ed Morrow, of Selma.

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ASHEVILLE NORTH CAROLINA



An institution for the diagnosis and treatment of psychiatric and neurological illnesses, rest, convalescence, drug and alcohol habituation.

Insulin coma, electroshock and psychotherapy are employed. The institution is equipped with complete laboratory facilities, including electroencephalography and x-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facilities for classification of patients, rooms single or en suite.

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Phone, 595-1151

is a private psychiatric hospital established in 1925 for the treatment of nervous or mental disorders, alcohol or drug addiction problems.

The hospital accepts both men and women. It is departmentalized according to sex and the degree of illness, with different sections for the acutely ill patient, the mildly ill patient, the convalescent patient, and the chronically ill resident patient. All rooms are private.

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American Hospital Association
American Psychiatric Association
National Association of Private Psychiatric Hospitals
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After Surgery: B and C vitamins are therapy

Therapeutic amounts of B and C in stress formula vitamins often are vital during periods of physiologic stress. STRESSCAPS, designed to meet increased metabolic demands, aids in achieving a more comfortable convalescence, a more rapid recovery. After surgery, as in many stress conditions, STRESSCAPS vitamins are therapy.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
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Vitamin B_{12} Crystalline	4 mcgm.
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Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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in common
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COMPOSITION:
diperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:
Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.





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COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

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one place your hay-fever patient doesn't need **ORNADE**® (unless he has a cold)

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Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

...but if your patient can't get away from hay fever, relieve sneezing, weeping and nasal congestion for 24 hours with one 'Ornade' Spansule® brand sustained release capsule q12h

Summary of contraindications, cautions and side effects: Do not use in patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction. Use with caution in the presence of hypertension, hyperthyroidism, or coronary artery disease. Drowsiness; excessive dryness of nose, throat or mouth; nervousness or insomnia may occur on rare occasions but are usually mild and transitory.

Before prescribing, see SK&F product Prescribing Information.

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OBITUARY

DR. ALBERT C. JACKSON

Dr. Albert C. Jackson died March 10, 1965. Doctor Jackson received his medical degree from Tulane University. He interned at Charity Hospital where he also took one year of surgical residency. He was a veteran of World War I, U. S. Army Medical Corps. Doctor Jackson was chief of the Surgical Service at Walker County Hospital from 1923 to 1957 and recently served as Chairman of the Building Committee of this institution now known as the Jasper Community Hospital. He was a member of the Walker County Medical Society, the Medical Association of the State of Alabama, the American Medical Association, a Fellow of the American College of Surgeons and of the International College of Surgeons, and a member of the Southeastern Surgical Congress. He was also Life Counsellor of the Medical Association of the State of Alabama. Doctor Jackson was one of the original organizers of Blue Cross-Blue Shield of Alabama which he served as Chairman of the Board for 5 years. In private life he was Chairman of the Board of Stewards of the First Methodist Church, Jasper, Alabama, for 13 years, President of the Rotary Club from 1933 to 1934. Survivors include his wife, Mrs. Enoree Jackson; two daughters, Mrs. Jean Belton Beech of Jasper, Alabama, and Mrs. Jacquelyn Snipes, Montgomery, Alabama; one son, Albert C. Jackson, Jr., of Washington, D. C., and five grandchildren.

Founded in 1904

HIGHLAND HOSPITAL, INC.

ASHEVILLE, NORTH CAROLINA
Affiliated with Duke University





A non-profit, psychiatric institution, offering therapeutic milieu, group and individual psychotherapy, and standard somatic treatments. Limited day-patient and out-patient services. The hospital is located in a 75-acre park amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation.

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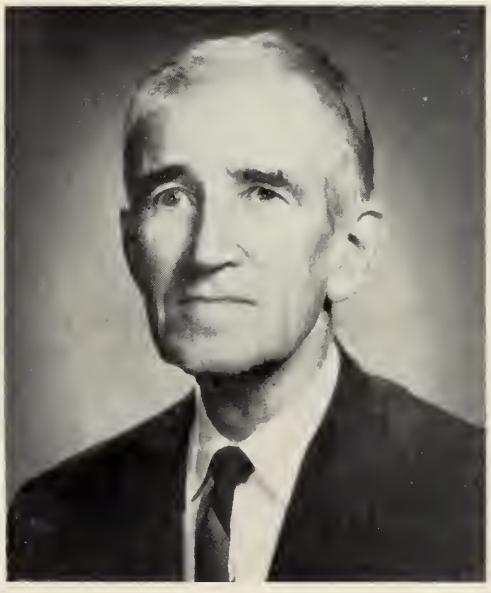
A Solfoton tablet or capsule at six hour intervals maintains sedation at the threshold of calmness. Usually the patient is not conscious of sedation; only conscious of feeling better. Safe for continuous use.
Each tablet or capsule contains: Phenobarbital, 16 mg. Warning: may be habit-forming. *Bensulfoid, 65 mg. Contra-indications: same as those of 16 mg. phenobarbital.

Dispensed in bottles of 100 and 500 tablets or capsules

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Manufacturers of ethical pharmaceuticals since 1856

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Dr. Otis L. Chason

Introduced by the

Mobile County Medical Society

A RESOLUTION

WHEREAS, Financial support of the official public health department by this state and many of its counties and municipalities has long been extremely poor, although there is ever-growing popular awareness of public health importance and demand for services; and

WHEREAS, This poor support causes inadequacy of personnel in number and often in qualifications, deficiencies of services, poor reports and publicity, and continually increasing citizen feeling of dependency upon and need for special, single disease or disease-class, programs; and

WHEREAS, The essentiality of effective public health organization in state and local government is based broadly, including, beyond the legal and interpretative guidance of

citizen action and sanitary standards; large volume and variety of technical and professional services; an ever increasing task of collecting, employing and providing, the records of people and of the conditions they experience or must control; and maintenance of comprehensive public health problem appraisal, and exercise of supports and adaptations to effect balance, economies, and efficiency in our public health programs; and,

WHEREAS, It is indisputably evident that no set or series of separately developed single or disease-class control programs, no matter how excellent in character or in community support, can provide well-rounded and efficient public health protection and promotion, which require clearly not only the powers and coordinative functions of state and local government but also breadth as well as depth of knowledge and concern, and freedom from unbalanced devotion to special conditions and services; and

WHEREAS, It was primarily a purpose of obtaining best available knowledge, understanding, and interest in all conditions affecting public health, that actuated the City of Mobile in 1841 and the State of Alabama in 1875 in establishing our outstanding system of basic public health organization, whereunder the respective medical organizations, State and county, select and elect capable members to assume the responsibilities and functions of legally constituted, official, public health boards; and

WHEREAS, This public health organization is no less an official agency of the State Government, and of each county and municipal government thereof, because of the medical membership of its basic boards; but, rather, this is a gift of medically educated public health judgment and a symbol of professional devotion to the public welfare, as fully public in representation as could be obtained under any method of board selection; but, we hope and believe, with exceptional capacities and no less exceptional freedom from bias or undesirable influence; and

WHEREAS, The capacity of this basic organization to develop a service organization and public health program which attracted world-wide interest and study was demonstrated, with much credit to the State and great gratification of our citizens and governing bodies, before the financial stringencies of the Depression crippled it; but poverty is continuing inequitably, even to this critical time and stage, to disable this public health organization in its efforts to recruit well qualified personnel and progress creditably in needed public health services; and

WHEREAS, This public health organization merits and requires strong financial and legal support of the Legislature and of the governing bodies of all counties and municipalities, if it is to be enabled to meet the important needs of the citizens;

THEREFORE BE IT RESOLVED, That the Medical Association of the State of Alabama declares again in the public interest its comprehensive support for and of a progressive, balanced and effective, public health program under the legally constituted public health organization, operating in fully proper response to the needs and rights of the citizens; and solicits earnestly the commensurate support of the governing bodies of the State, counties and municipalities.



..nothing, that is, except the
sedative-antispasmodic action of

Donnatal®

Prescribed by more physicians than any other antispasmodic —*well over 5 billion doses!*

*This one at Navajo Loop Trail, Bryce Canyon National Park, Utah

By its combination of natural belladonna alkaloids with phenobarbital, DONNATAL provides potentiated antispasmodic action unsurpassed in its record of dependable efficacy and safety.

Contraindications: Glaucoma, advanced renal or hepatic disease, or hypersensitivity to any ingredient. *Precautions:* Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction as in prostatic hypertrophy. *Side Effects:* Blurred vision, difficult urination, or flushing and dryness of the skin may occur at higher dosage levels, rarely at the usual dosage.

In each Tablet, Capsule or 5 cc. Elixir		In each Extentab®
0.1037 mg.	hyoscyamine sulfate	0.3111 mg.
0.0194 mg.	atropine sulfate	0.0582 mg.
0.0065 mg.	hyoscine hydrobromide	0.0195 mg.
16.2 mg. (¼ gr.)	phenobarbital (¾ gr.)	48.6 mg.

(Warning: may be habit forming.)

A. H. ROBINS CO., INC., RICHMOND 20, VA.


for the
patient with
'pain &
spasm'

to assure pain relief in relaxant therapy

In painful skeletal muscle spasm, relief of pain does not always follow relaxant therapy, as in the presence of—

Provocative pain, when muscle spasm is triggered by some underlying musculoskeletal defect.

Residual pain, when relaxation of severe spasticity leaves a degree of myalgia that continues to cause discomfort.

Severe pain, when the degree of pain is such as to cause persistence of symptoms in spite of relaxant therapy.

Emotionally aggravated pain, when anxiety or agitation creates tensions that undermine the efficacy of relaxant medication.

For decisive relief—lest persistent pain overshadow the benefits of relaxant therapy—many physicians prescribe ROBAXISAL or ROBAXISAL-PH.

Synergistic double action

In ROBAXISAL the potent action of the well-recognized skeletal muscle relaxant Robaxin (methocarbamol)[1,2,3,4,5,6,8] is accompanied by the time-tested analgesia of aspirin. This "rational therapeutic combination"[7] proves especially effective, since clinical studies have attested that the concurrent ingestion of methocarbamol and aspirin produces higher salicylate levels than equivalent doses of aspirin alone[7]...with "gratifying relief" of pain as well as spasm.[7]

INDICATIONS: Strains and sprains, painful disorders of the back, "whiplash" injury, myositis, pain and spasm associated with arthritis, torticollis, and headache associated with muscular tension.

CONTRAINDICATIONS: Hypersensitivity to any one of the components.

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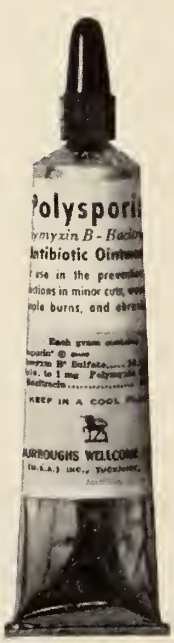
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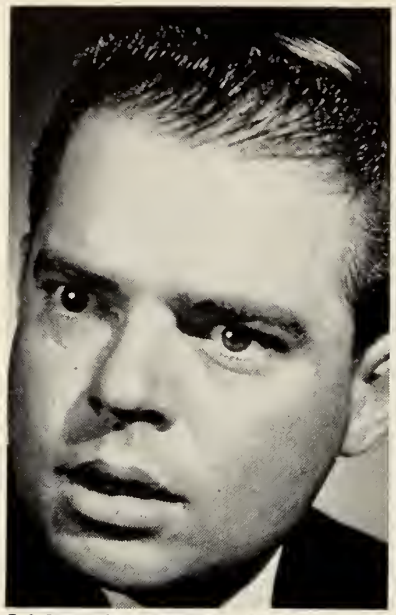
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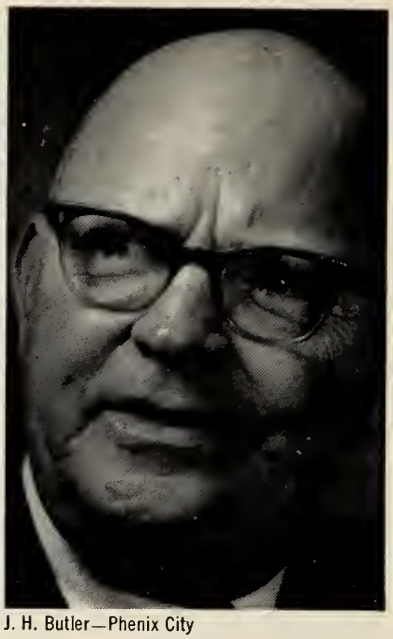
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To find out whether hearing is fading, the first person to consult is the family doctor, says a pamphlet of the American Medical Association.

The physician may find that the hearing loss is due to impacted wax in the ear canal or some other obstruction. Or there may be an infection that can block the transmission of vibrations inside the ear or affect the nerves of hearing. Certain drugs and industrial chemicals can affect hearing; and mumps and scarlet fever, a cold or acute sinusitis frequently cause swelling of the mucous membranes associated with the ear. A very loud noise or a sharp blow may damage the eardrum.

The physician can determine by a variety of tests whether loss of hearing is due to nerve damage or to an interference with the transmission of sound waves. If there is obstruction, he can tell whether it is due to infection or another cause. He will determine whether treatment will help or correct the hearing problem. Several surgical procedures are used to help the deaf to hear, and there also are medical treatments.

In many cases, however, treatment cannot restore hearing; and then a hearing aid may be prescribed.

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In cases of severe hearing loss it is frequently necessary to complement a hearing aid with lip reading to secure maximum communication. Most larger communities and many small ones today have therapists qualified to give instruction in lip reading. Your physician can help you find one. Many hard of hearing people find that they already are lip reading to some extent without realizing it.

Ignoring a hearing loss will never make it disappear. As soon as the hearing loss is recognized, seek medical help. Often there is much that can be done to help the hard of hearing continue to fill a normal place in society.

An Objective Review Of Drug Safety

It behooves us to try to work out some reasonable approach so that the patient can be protected but not be discriminated against because of fears and anxieties in regard to the use of drugs. It seems that we should all support the efforts of establishing a committee of medical scientists independent from both the government and manufacturer to which such matters can be referred for evaluations of safety. In this way the private practice of medicine can function more adequately and feel more comfortable in knowing that the drugs are being reviewed in a more objective manner.—Louis M. Foltz, M. D., in *Journal Kentucky Medical Association*, 62: 10, (Oct.) 1964.

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Dr. Eugene M. Regen, Nashville, Tennessee, will lecture on "Management of the Low Back Problem."

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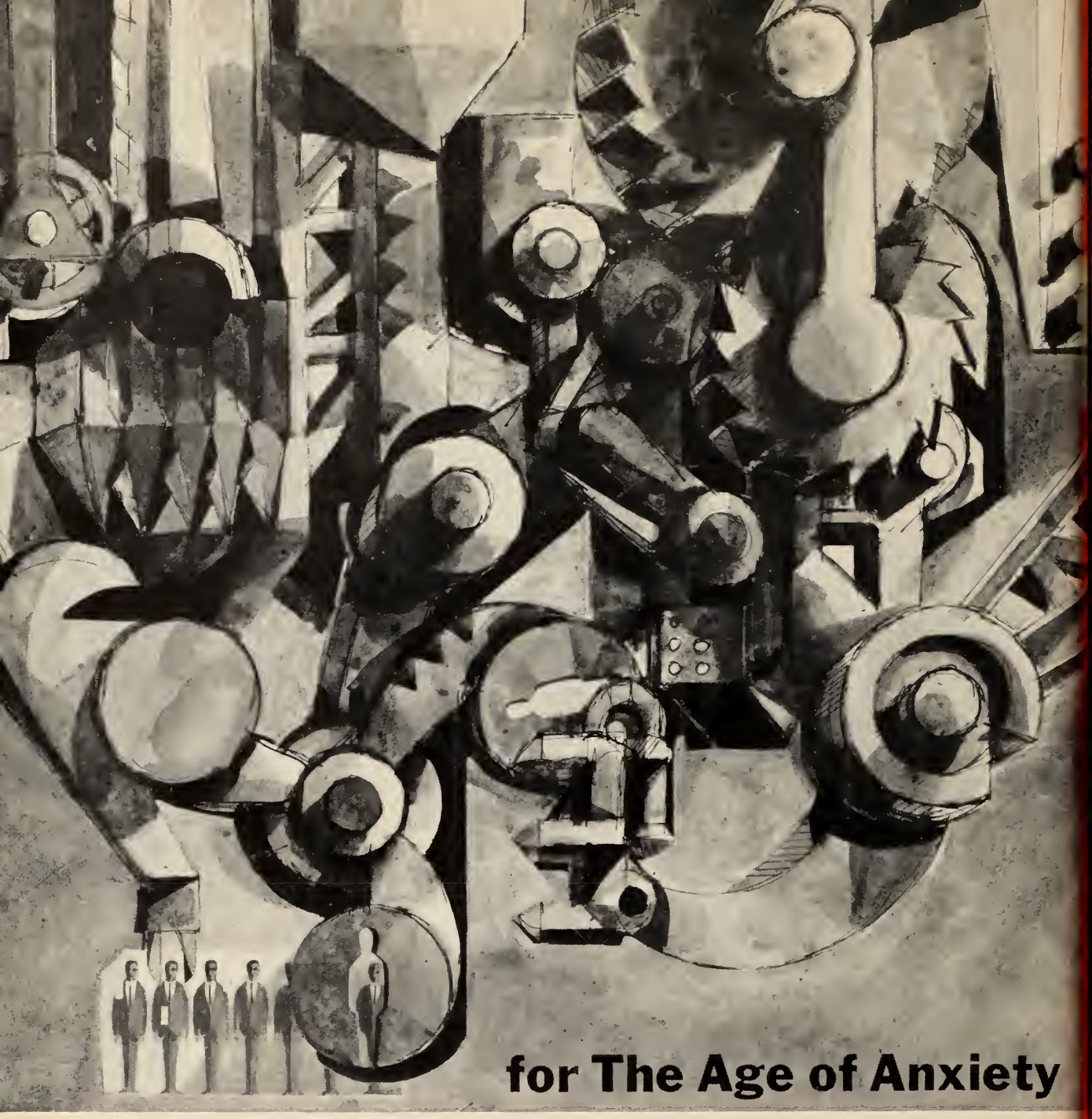


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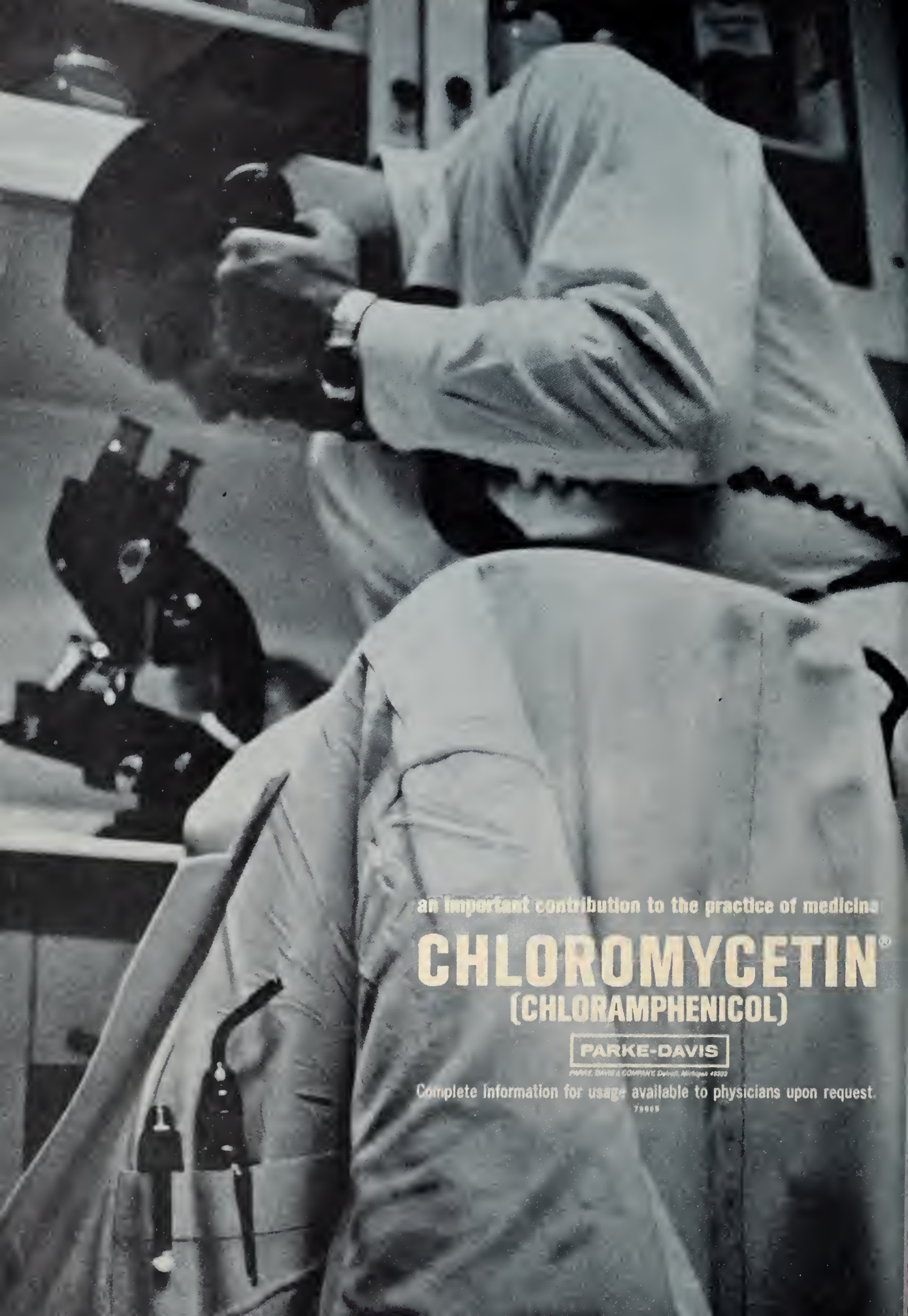
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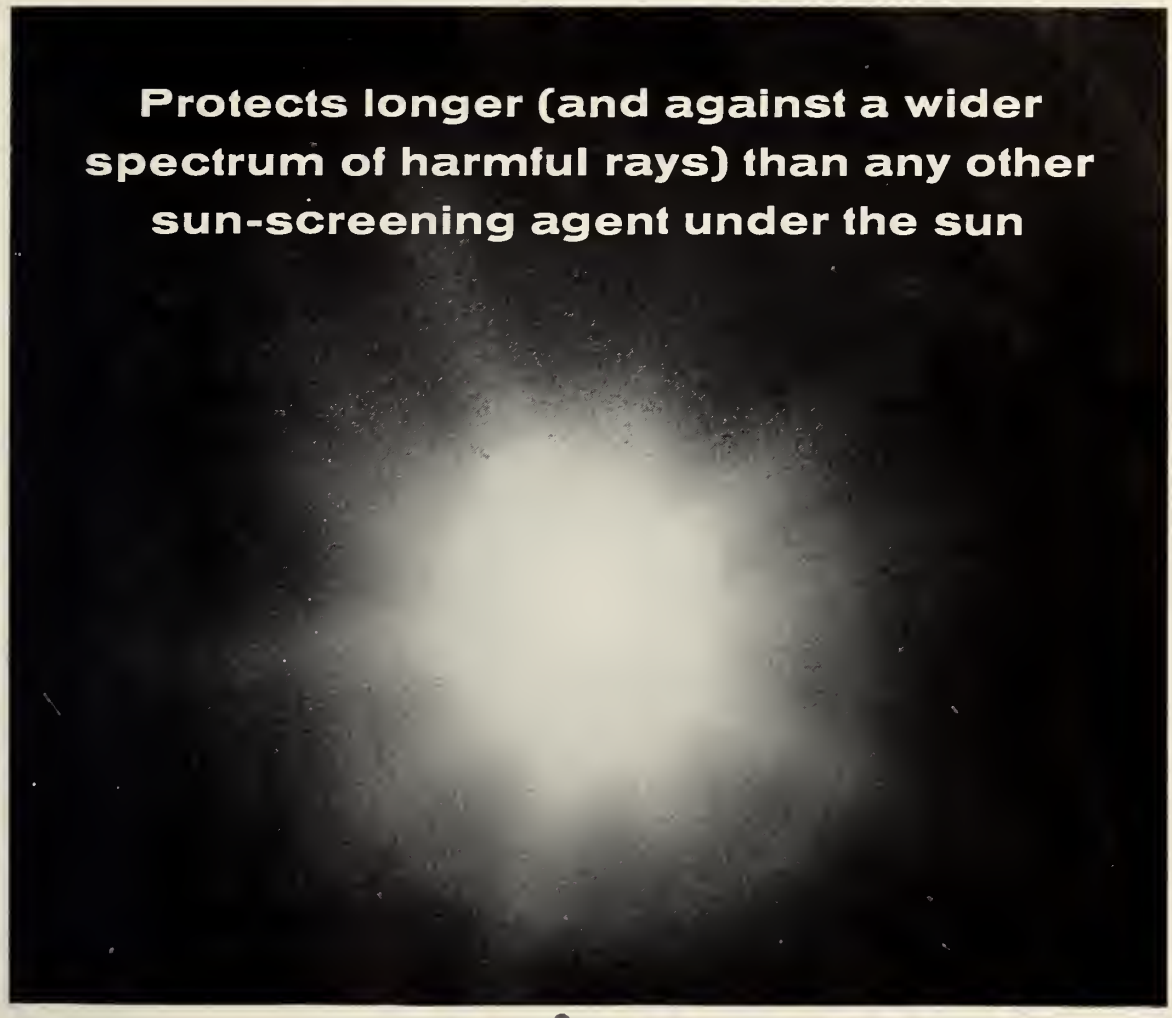
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President's Page

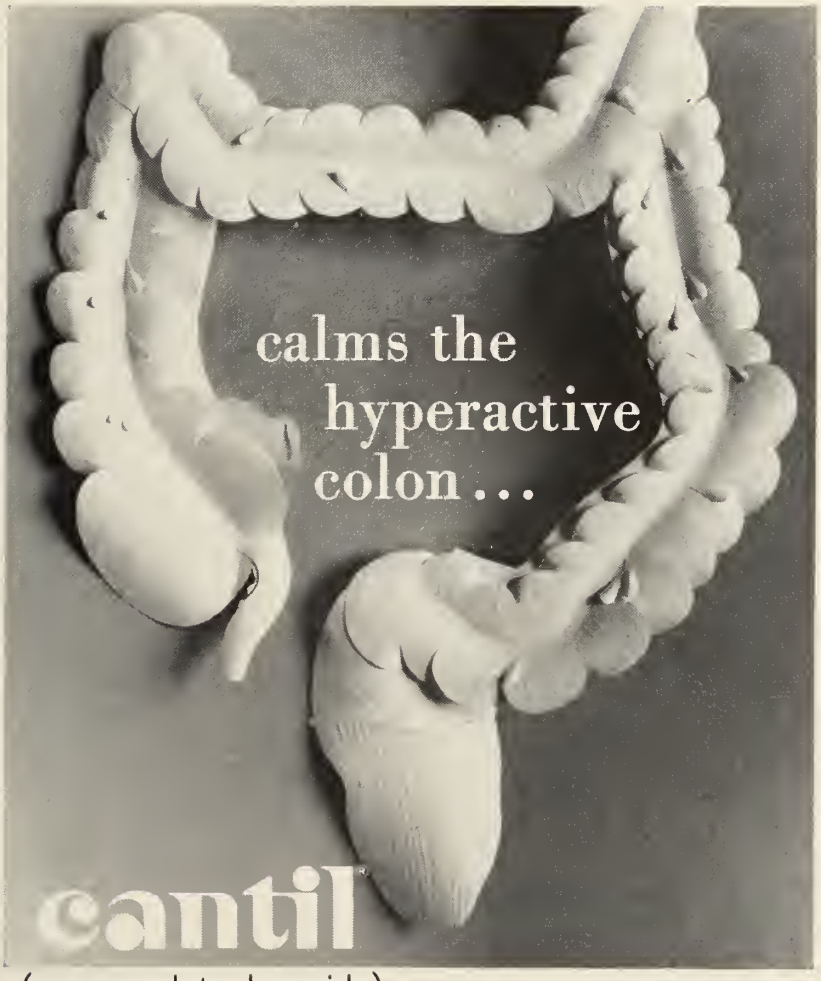


On June 20th-24th, 1965, it was my privilege to attend the meeting of the House of Delegates of the American Medical Association at the Americana Hotel in New York. Although I have previously attended many of the scientific sessions of the AMA, this was my first opportunity to observe the House of Delegates in action. It made me proud to be a member of such a democratic and efficient organization. The House of Delegates is the policy-making body of the AMA. Its decisions affect patient care and medical practice in the entire nation. Possibly a description of the detailed operation of this particular session of the House of Delegates will be of interest to the members of the Association.

The House of Delegates convened on Sunday afternoon, June 20th, for a most impressive ceremony, with introduction of the various officers of the American Medical Association, the Presidents of State Medical Associations, and many other distinguished guests. Thereafter Dr. Donovan F. Ward, outgoing President, presented his report, following which the Chairman of the Board of Trustees, Dr. Percy E. Hopkins, installed the new President, Dr. James Z. Appel, who gave his inaugural address.

The second session of the House of Delegates convened on Monday morning. Reports of the Board of Trustees; the standing committees of the AMA which are known as Councils; special committees such as the Gundersen Committee to review the Organization of the House of Delegates; and finally, resolutions from State delegations and individual delegates were introduced. Seventy-four such resolutions were introduced at this session alone, many of them dealing with the controversial subject of non-participation in the pending "Medicare" legislation. Each of these reports and resolutions was referred to the proper Reference Committee. These Reference Committees, 13 in number, had previously been appointed from the 235 delegates. Each of the Reference Committees had five members, including the Chairman. It was interesting to those of us from Alabama that Dr. E. Bryce Robinson, Jr., served as Chairman of the Reference Committee on Credentials. At each of the sessions of the House of Delegates he rose to certify that the credentials of 234 of the 235 delegates were in order. The two other delegates from Alabama, Dr. John Chenault of Decatur, and Dr. M. Vaun Adams of Mobile, have served on important Reference Committees on many previous occasions, but were not so assigned this year. Each of the delegates from Alabama was faithful in attendance at the meetings of the House of Delegates and was held in high esteem by delegates from all parts of the country.

The Reference Committees conducted hearings on the various reports and resolutions which were referred to them. These hearings took place on Monday afternoon and Tuesday. Much to my surprise, the Reference Committee hearings afforded an opportunity



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"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects. Blurring of vision or dryness of the mouth were occasionally seen and were usually managed with a reduction in dosage. Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF:

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1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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for everyone to present his views to the Committee whether or not he or she was an official delegate. Any members of the AMA, any State Officers, and even interested parties who were not members of the AMA had the privilege of being heard by the Reference Committee concerned with the problem in which they were interested. I attended the hearings of the Reference Committee on Legislation and Public Relations, to which was assigned all the resolutions of nonparticipation and the portion of President Appel's inaugural address which dealt with nonparticipation. More than 80 witnesses were heard by this Reference Committee on Monday afternoon and Tuesday morning. It then went into executive session to digest the material which had been presented to it and to come up with a final recommendation to the House of Delegates. It is rumored that this Committee was in executive session all of Tuesday night and a portion of Wednesday morning.

The third session of the House of Delegates convened on Wednesday morning for consideration of the recommendations of the various Reference Committees and for nomination of officers. Each of the Reference Committee reports was discussed and amended freely by members of the House of Delegates. The final amended resolutions which were approved by the majority of the House of Delegates constitute the current policy of the AMA. The Board of Trustees and the Officers of the Association are obligated to abide by these decisions of the House of Delegates. A report of the actions of the House of Delegates has already been sent to each member of the Medical Association of Alabama by the members of our delegation. This session of the House of Delegates lasted all day Wednesday, and the fourth session convened Thursday morning. After concluding the action on the various Reference Committee reports, the officers of the AMA were elected from the group which had been nominated the afternoon before. Dr. Charles L. Hudson, of Cleveland, Ohio, a member of the AMA Board of Trustees since 1961, was named President-Elect. Dr. M. Vaun Adams had seconded his nomination for the majority of the Alabama delegation. Dr. Hudson defeated Dr. Walter Judd and Dr. Durwood Hall, who is also a member of the U. S. Congress.

After observing the House of Delegates making policy for the American Medical Association, it is my conclusion that we have a very effective and representative organization which can and should speak for the vast majority of American doctors.

James G. Donald, M. D.

James G. Donald, M. D.

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OCTOBER

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SIDE EFFECTS: Blurring of vision, dry mouth, difficult urination or flushing and dryness of the skin may occur at higher dosage levels, rarely at the usual dose.

*This one at Oak Creek, Castle Rock, Arizona

References: 1. Hock, C. W.: Clin. Med. 8:1932, 1961. 2. Marks, L.: Am. J. Gastroenterol. 27:180, 1957. 3. Palmer, W. L., and Kirsner, J. B.: Therapeutics in Internal Medicine, 2nd ed., F. A. Kyser, Ed., Hoeber, New York, 1953, p. 368. 4. Ryan, J. P., Jenkins, H. J. and Robinson, S. M.: J. Pharmaceut. Sciences 53(9):1084, 1964. 5. Vollmer, H.: Arch. Neurol. & Psychiat. 43:1057, 1940. Abst. J.A.M.A. 115:333, 1940. 6. Wharton, G. K., Balfour, D. C., Jr., and Osman, K. I.: Postgrad Med. 21:406, 1957.

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Contraindication: Pediamycin is contraindicated for patients with known sensitivity to erythromycin.

Precautions: Side effects are relatively rare. Should a patient show signs of hypersensitivity, appropriate countermeasures (e.g., administration of epinephrine, steroids, etc.) should be employed and the drug withdrawn.

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*Done, A. K., in Drugs of Choice 1964-1965, Modell, W., ed., St. Louis, The C. V. Mosby Co., 1964, p. 66.

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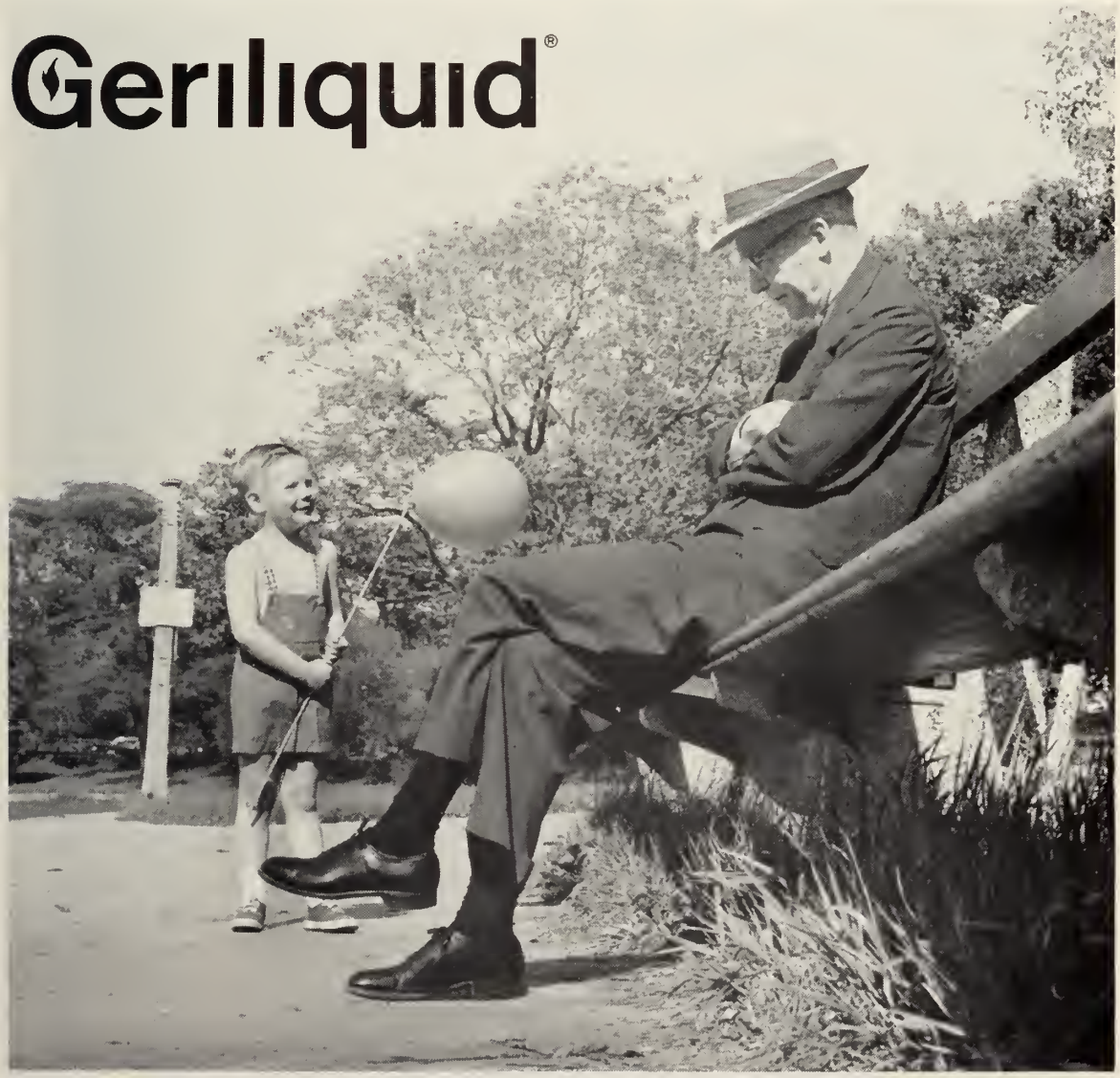
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*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

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IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

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Vol. 35 August, 1965 No. 2

Posttraumatic Epilepsy*

by

A. Earl Walker, M. D.**

Introduction

Four-hundred years ago Duretus[3] wrote of a youth whose skull had been broken and depressed by a fall at the age of 12, and who, in his 18th year suffered from epilepsy "because of the oppression of the brain." Such references to posttraumatic epilepsy before 1900 were rare, because few victims survived a severe cranio-cerebral injury long enough to develop seizures. With modern methods of treatment the severely injured patient is being salvaged to swell the population of potential posttraumatic epilepsies.

Pathogenesis Of Posttraumatic Epilepsy

The pathogenesis of the posttraumatic seizures, probably is somewhat more complicated than the symptomatic epilepsy associated with cerebral afflictions such as abscess or tumor, in that the initial insult introduces acute factors which are not operative in the more chronic conditions. Once the laceration, hemorrhage and edema have resolved, the chronic traumatized brain would seem to be subjected to epileptogenic factors common to all brain afflictions characterized by connective tissue and glial reaction.

Factors relating to the injury itself unquestionably are important, particularly the severity or degree of brain injury, and the cerebral structures involved. The severity of injury may be assessed on the basis of a number of parameters of injury (a) the type of wound, (closed or open, penetrating etc.), (b) the agent, (c) the size of the cranial wound, (d) the depth of the wound, (e) the presence of retained foreign bodies, (f) the period of unconsciousness, (g) the length of posttraumatic amnesia, and (h) the neurological deficit. Increasing gravity of any of these factors is associated with a greater likelihood of epilepsy, but no one parameter correlates completely (table 1). For this reason,

Table 1

Relation of Epilepsy to Depth of Wound

Depth of Wound	Epilepsy (percentage)		
	Ascroft (N=299)	Caveness (N=356)	Walker & Jablon (N=207)
Scalp	24		15
Dura mater	23	19.5	17
Brain	45	50	41

*Supported by a grant from the National Institutes of Health, Bethesda, Maryland.

**From the Division of Neurological Surgery, The Johns Hopkins University, School of Medicine, Baltimore, Maryland.

Presented at the Alabama Academy of Neurology, Neurosurgery and Psychiatry, April 22, 1965.

attempts have been made to integrate these various factors into a formula which might be used as an index of the risk of an epilepsy. Walker and Jablon[9] have incorporated some 15 factors into an injury score. Caveness[2] has graded the severity of injury in terms of categories based upon a half dozen parameters. Ritchie Russell and Smith[6] believe that of 100 different signs and symptoms, the posttraumatic amnesia emerges as the most sensitive and reliable index for cases without signs of focal damage that is in cases of closed head injury. The location of the brain injury as a factor in the likelihood of an epilepsy has been less well accepted than the severity of injury.

In the monkey and probably in man, the thresholds for after-discharge to electrical stimulation are lowest in the motor cortex, the hippocampus, amygdala and anterior temporal cortex in approximately that order. Other areas of the cortex—postcentral gyri, prefrontal, occipital and posterior temporal—have an increased threshold, and most subcortical ganglia have a still higher threshold for after-discharge. Theoretically, damage to the first group should be associated with a greater incidence of posttraumatic epilepsy than injury to the other neuronal masses, and, in general, this is true (table 2).

The effect of age upon the likelihood of posttraumatic epilepsy is not clear. Although the incidence of epilepsy in children under 16 years of age is approximately the same as that of adults, and old people do not appear more likely to develop seizures after head injury than younger individuals, a more definitive statement regarding susceptibility and age cannot be made.

Other factors unrelated to the injury itself may be introduced some time after the violence.

(1) Bleeding into or about the brain.

(2) Edema of the brain.

(3) Iatrogenic punctures of the brain.

(4) Infection.

The occurrence of these factors tends to increase the likelihood of a posttraumatic epilepsy.

Manifestations Of Posttraumatic Epilepsy

Posttraumatic epilepsy, although characterized by abnormal stimulation or depression of a localized cerebral function may or may not be initiated by phenomena apparent to the subject or to observers. The initial discharge may be present for some time before it propagates and stimulates a cerebral area which produces overt manifestations. Only then, if it does not impair consciousness, or does not distort memory processes, is it recognized by the subject as the warning or aura of the attack. In reality, the aura is an early manifestation of the epileptic process and should not be considered as something

Table 2

Relation of Location of Missile Wounds with Dural Penetration and Epilepsy in Four Series*

Region	Number in series I	% epilepsy	Number in series II	% epilepsy	Number in series III	% epilepsy	Number in series IV	% epilepsy
Prefrontal	35	31	8	12	160	39	153	28.8
Frontal	28	54	51	45	127	55		
Parietal	17	52	34	65	170	65	213	40.1
Temporal	23	59	18	22	71	38	79	14.9
Occipital	22	41	17	23	73	38	86	16.2

* Series I—Ascroft
Series II—Caveness
Series III—Russell & Whitty
Series IV—Walker & Jablon

distinct from the attack. At times it may be its only manifestation but usually it eventually spreads to anatomically and physiologically related cerebral areas to induce a tonic-clonic convulsion with loss of consciousness.

Approximately one-fourth of patients with posttraumatic epilepsy have no conscious appreciation of the onset of their seizure. These attacks may be initiated by objective focal manifestations such as adversive movements of the head and eyes or may begin with a sudden generalized convulsion. They follow wounds of any part of the brain but are most commonly the sequelae of frontal lobe injuries (fig. 1).

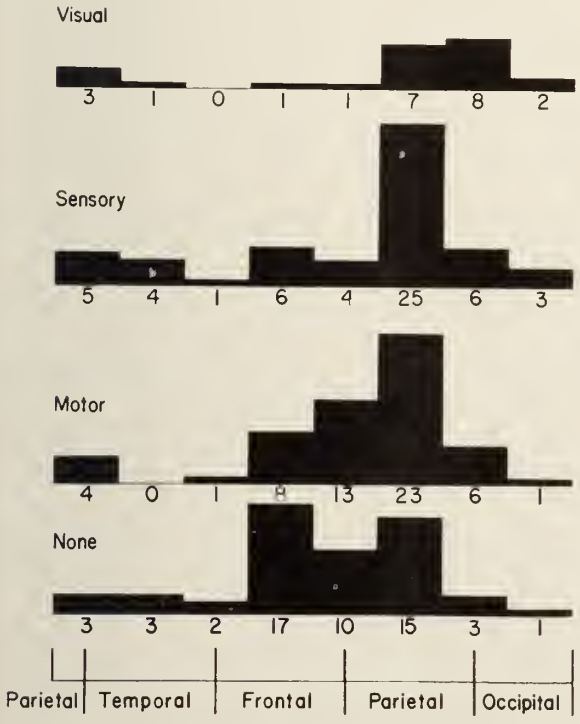


Fig. 1. Histograms to indicate the location of cortical wounding in patients having visual, somatosensory, motor and no warnings of their attacks. The number of patients in each column is represented by the figure below the histogram. Lesions involving two lobes are indicated by the column above the vertical lines separating the names of the lobes.

The typical focal motor attack, which occurs in about 25 per cent of posttraumatic epileptics, is initiated by a sudden jerking or stiffening of the arm or leg, or by the abrupt loss of power in a member. The muscular contractions may occur in any part of the body, but most frequently in the face, hand or foot. These jerkings are often accompanied by a paresthesia of the involved part. The tonic or clonic movements may march to involve the entire limb, as described by Hughlings-Jackson and then proceed to implicate the other ipsilateral extremity and half of the body before becoming generalized. These focal motor seizures are usually associated with wounds of the central region.

Focal sensory attacks initiated by paresthesias, such as numbness, tingling, cold etc., of the hand, face or leg, tend to spread as the motor seizures, and in fact may be associated with twitching of the paresthetic part. They, too, may become generalized or stop at any stage in their evolution. They are likely to be associated with wounds of the central or parietal region.

Less commonly sensory hallucinations initiate the fit. Visual, auditory, olfactory or vertiginous sensations are related to lesions of the occipital, superior temporal, orbital temporal and inferior parietal regions of the brain respectively. The typical psychomotor seizure associated with automatisms, autonomic motor or sensory phenomena, with or without psychic disturbances is rarely encountered in adults following head injuries. In about 10 per cent of cases, the posttraumatic seizure is a bizarre episode, characterized by faintness, dizziness, weakness, staring, with or without motor concomitants. These phenomena may constitute the entire attack or on occasions, they may progress to a generalized tonic-clonic seizure. Unfortunately, the manifestation of vasomotor instability frequently seen in the convalescent period of a head injury, are so similar that they may be mistaken for epileptic seizures, especially if the electroencephalogram shows some abnormality. However, the relationship

of the vasomotor symptoms to posture and the fact that in time they tend to clear up, differentiates the two conditions.

Even if the attack can be definitely classified as epileptic, the assumption that it bears more than a temporal relationship to a head injury, is not necessarily justified. A number of criteria have been set up for evaluating the etiological relationship of a seizure to head trauma.

(1) that the individual should have had no history of pretraumatic convulsive manifestations.

(2) that the patient should not have other systemic or cerebral conditions which might reasonably be associated with convulsions.

(3) that the alleged trauma was of such magnitude that, with reasonable certainty, brain damage resulted. This may be based upon the consideration of

(a) the duration of loss or impairment of consciousness.

(b) the extent of the neurological deficit following the head injury.

(c) the extent of the wound of the scalp, skull or brain.

(d) the presence of roentgenographic evidence of cranial fracture.

(e) the presence of blood in the spinal fluid after the injury.

(f) the degree of abnormality, especially focal, in serial electroencephalographic recordings, and their correspondence to the type of seizure.

(g) special tests for brain structure and function, such as psychometric tests, pneumoencephalograms, etc.

(4) that the alleged attacks must be bona fide epileptic.

(5) that the onset of the first epileptic manifestation was not too long after the injury.

(6) that the type of epilepsy, the site of brain injury and the electroencephalographic abnormalities correlated.

The Time Of Occurrence Of The First Attack

Immediate fits. Within a second or two of an acute head injury, approximately one per cent of individuals developed a generalized convulsive attack presumably as the result of direct mechanical stimulation of cerebral structures having low epileptogenic thresholds.

Early posttraumatic epilepsy. Convulsive manifestations usually focal, occurring within the first month, generally have been considered to be the result of tearing, laceration, hemorrhage of brain tissue and secondary cerebral reactions. The occurrence of such attacks within the first few days may compromise the delicate balance between life and death in the case of a severe head injury. Many writers believe that such early attacks are not necessarily followed by chronic recurring seizures, and, in fact some authors would not classify them as posttraumatic epilepsy.

Late epilepsy. Seizures developing after one month are usually attributed to scarring of the brain and are considered to have a somewhat poorer prognosis than those with an earlier onset.

The Risk Or Incidence Of Epilepsy

The risk of an epilepsy in any particular population of head injured individuals depends to a considerable extent upon the source of the series, since head injuries from a residential area, an industrial zone or congested traffic districts are caused by different agents, inflicting varying degrees of violence (table 3).

In closed head injuries, an incidence of 1-5 per cent of posttraumatic epilepsy has been quoted on the basis of a number of series. In general, one may say that an individual with a closed head injury without clinical neurological abnormalities, with impairment of consciousness for no more than one hour. if free of attacks for the first month after injury, has about two chances in a thousand of developing a fit later (table 4).

Table 3

The Risk of Epilepsy Following Various Types of Head Injuries Related to the Period of Unconsciousness

Type	Estimated Incidence of Wound Type in General Hospital Population (%)	Loss of Consciousness		
		None	Less than 1 hr.	More than 1 hr.
		(risk of epilepsy %)		
Scalp Contusion				
No fracture	50	1	2	5
With linear fracture	25	2	2	10
With depressed fracture	2	5	10	20
With brain laceration	1			
Scalp Laceration				
No fracture	10	1	2	5
With linear fracture	5	2	2	10
With depressed fracture	4	5	10	20
With brain laceration	3	20	25	30

For complicating extradural or subdural hemorrhage, add 20% to risk of epilepsy; for infection or exploratory trephines, add 10% to the risk.

Evidence of cortical motor or sensory paralysis doubles the primary risk of epilepsy.

Compound wounds of the brain, however, have a much greater risk of both an early and late epilepsy. In such wounds the severity and location of the cerebral injury play an important role in determining an epilepsy, whereas, the length of unconsciousness is not quite such a good index of the likelihood of an epilepsy. In dural penetrating head injuries, one may conclude that an epilepsy may develop in 20-50 per cent of cases. Approximately six months after injury, half of the patients who will develop epilepsy have had their first attack, and by the end of two years, 80 per cent will have experienced a seizure. After that time, from the third to the tenth year, the incidence of new cases of posttraumatic epilepsy is approximately one per cent a year (fig. 2).

However, a certain percentage of individuals having had attacks for a few years, will cease having such episodes. Between 25-50 per cent of individuals who developed posttraumatic epilepsy, about the third year will have fewer and less severe attacks. This spontaneous remission does not seem to be dependent upon the type of amount of anticonvulsant medication but is related to (1) the early occurrence of a few attacks, (2) an early cessation of attacks, and (3) a low frequency of attacks. There is a tendency for the focal attacks to be less severe and to be arrested before they become generalized.

Electroencephalography In Posttraumatic Epilepsy

Serial electroencephalograms of head injured men indicate that the abnormalities seen immediately after a head injury tend to revert to normal within a period of three to six months. The persistence of either generalized and/or focal abnormalities correlates with clinical evidence of brain damage, but not necessarily with an epilepsy. At best, the brain waves indicate the severity of brain injury which correlates as noted previously, only roughly with the likelihood of an epilepsy. Nor is the electroencephalogram of

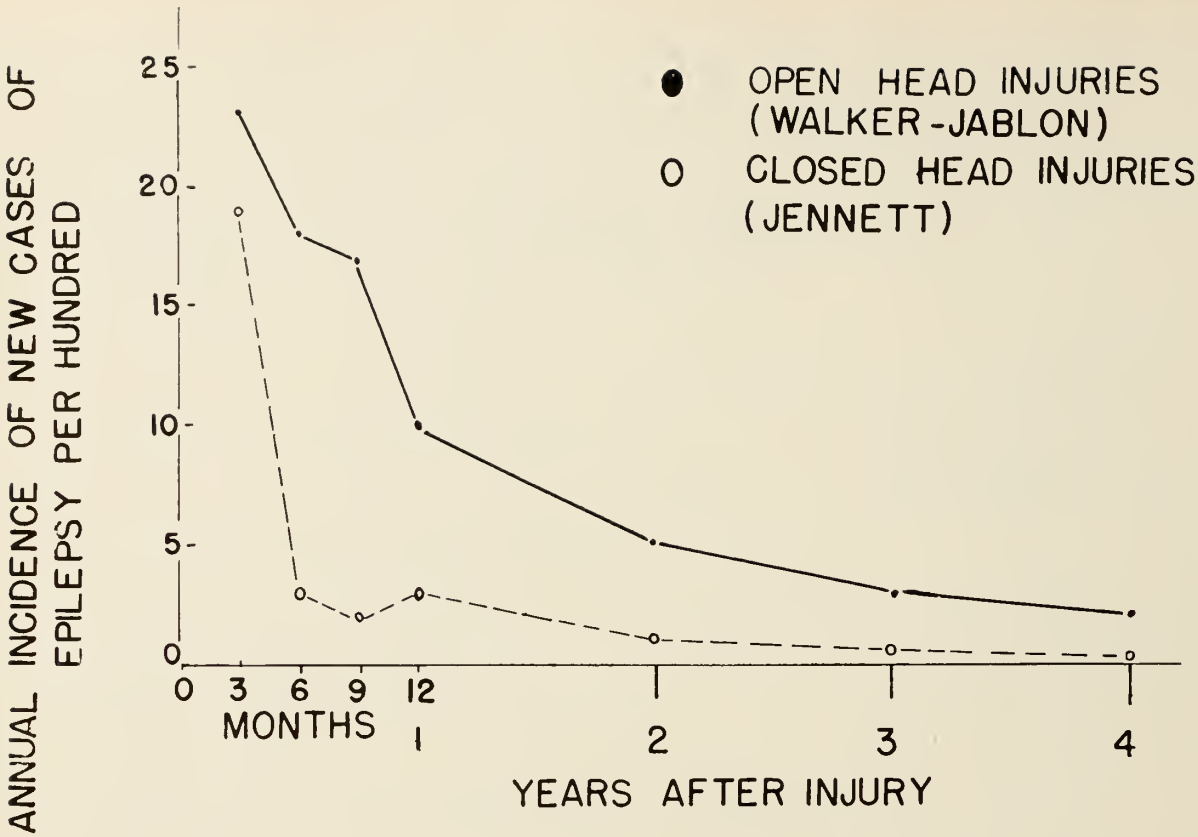


Fig. 2. A graph of the annual incidence of new cases of epilepsy per hundred head-injured victims. The continuous line represents patients with open head injuries, and the interrupted line represents patients with closed head injuries.

great value in indicating as to whether an individual will continue to have attacks once they have developed (table 5).

The Therapy Of Posttraumatic Epilepsy

Unfortunately well controlled series of patients having head injuries treated by anticonvulsive medication has not been studied, so that the prophylactic value of such drugs is not yet validated. Many surgeons believe that patients with penetrating wounds of the dura in whom the chances of a convulsion developing are close to 50 per cent, should be given anticonvulsive drugs such as phenobarbital, grs. one, two or three times a day, or dilantin, grs. 1½, three times a day. If attacks do not develop within two years, these drugs may be gradually discontinued. Perhaps of equal importance is the avoidance of alcoholic beverages for a year or two after a head injury and the regulation of the bowels to avoid constipation.

The surgical treatment of the posttraumatic epilepsy is related to early debridement, the evacuation of sub- and extra-dural hemorrhages. The late treatment of the epilepsy for recurrent seizures should be deferred until four or five years after the onset of the attacks to allow for the natural recession of some cases. If the patient continues to have attacks in spite of anticonvulsive medication after that time, and is otherwise in good physical condition, the focus delineated by electrocorticography may be resected.

Table 4

Incidence of Epilepsy in Closed Head Injuries*
And Dural Penetrating Injuries (from Walker)

Author	Closed		Dural Penetrating	
	No. cases	% epilepsy	No. cases	% epilepsy
World War I				
Alajouanine et al			602	37
Gamberini			138	62
Wagstaff			176	19
Rawling	47	9	226	33
Ascroft			129	45
Credner	244	19.7	1,234	49
Dubitscher			1,000	34
Steinthal & Nagel			348	40
Glidden			137	19
World War II				
Russell & Whitty	500	6		
Watson			500	42
Walker & Jablon	267	14.2	472	36
Wilson			196	17
Civilian				
Rowbotham	430	2.5		
Phillips	500	6.2		
Jennett	1,000	8.0**		
Korean				
Caveness	149	10	130	50

* Includes scalp lacerations.

**Deduced from 3.8% early epilepsy plus 5% late epilepsy of which ¼ to 1/3% were early epileptics.

Table 5

Electroencephalographic Findings as an Index
of Prognosis of Posttraumatic Epilepsy
(from Marshall & Walker)

Electroencephalographic characteristics 5-9 yrs. after onset of posttraumatic epilepsy.	State of Epilepsy After 5 Years			
	No attacks		Continuing attacks	
	No. cases	%	No. cases	%
Normal or borderline	27	39	56	34
Generalized abnormality	17	25	32	23
Focal abnormality	25	36	55	33

Summary

The pathogenesis of posttraumatic epilepsy is complicated and related to factors preceding, concomitant with, and subsequent to, the injury.

The incidence of epilepsy in head injuries varies from practically nil to over 50 per cent depending upon the severity of injury, and the site of cerebral involvement.

Even if seizures develop, there is a good possibility of spontaneous regression and cessation within 3-4 years of the injury.

The medical treatment consists of anticonvulsant therapy until the patient has become free of attacks for at least two years.

References

1. Ascroft, P. B.: Traumatic epilepsy after gunshot wounds of the head, Brit. M. J., 1941, 739-744.

2. Caveness, W. F.: Onset and cessation of fits following cranio-cerebral trauma. J. Neurosurg. 1963, 20: 570-583.

3. Duretus, L. in Hollerius, J.: Omnia opera practica. Doctissimis eiusdem scholis et observationibus illustrata: Deinde Lud. Dureti . . . in eundem enarrationibus, annotationibus, et Antonii Valetii D. Medici exercitationibus luculentis, Coloniae Allobrogum, 1623.

4. Jennett, W. B.: Epilepsy after blunt head injuries, London, W. Heinemann Medical Books, Ltd., 1962 + 150 pp.

5. Marshall, C. and Walker, A. E.: The value of electroencephalography in the prognostication and prognosis of posttraumatic epilepsy. Epilepsia, 1961, 2: 138-143.

6. Russell, W. R. and Smith, A.: Posttraumatic amnesia in closed head injury, Arch. Neurol., 1961, 5: 4-17.

7. Russell, W. R. and Whitty, C. W. M.: Studies in traumatic epilepsy: Factors influencing incidence of epilepsy after brain wounds, J. Neurol., Neurosurg., and Psychiat. 1952. 15: 93-98.

8. Walker, A. E.: Posttraumatic Epilepsy in "Acute Injuries of the Head" by G. F. Rowbotham, Edinburgh and London, E & S Livingstone Ltd., 1964, chapter 25: 486-509.

9. Walker, A. E. and Jablon, S.: A follow-up study of head wounds in World War II. VA Medical Monograph, Washington, D. C. Gov't. Printing Office, 1961, + 179 pp.

Amenorrhea And Birth Control Pills

Robert V. Barnett, M. D.

Birmingham, Alabama

There are many patterns of vaginal bleeding, or lack of it, that accompany correct and incorrect use of the oral contraceptives, or follow their use. Designating "amenorrhea" to describe them is improper. It was deliberately chosen, however, because amenorrhea so associates itself with pregnancy, and it is this association that must be clarified. These diagnostically troublesome situations include:

1. Frank amenorrhea while an established plan of cyclic medication is followed.
2. Amenorrhea with continuous, non-cyclic medication.
3. Extreme degrees of hypomenorrhea.
4. Irregular bleeding with illchosen or unadvised change in cyclic therapy with pregnancy and amenorrhea intertwined.
5. Prolonged cycles following cessation of therapy.

Unplanned pregnancies in all these circumstances are rare. Even so, one must be impressed with the need for and problem of accurate diagnosis of pregnancy, its complications, such as missed abortion, and the correct détermination of expected date of confinement. If no pregnancy is involved the episodes are usually of short duration, correct themselves spontaneously or with adjustment of the cyclic therapy, and are of no special physiologic or pathologic significance.

Frank Amenorrhea

Strictly speaking, amenorrhea has been defined arbitrarily as three consecutive months without menses. Rarely does involvement of this degree occur where the contraceptive tablets are correctly taken. The patient may fail to have recognizable menstruation after one cycle, less frequently after two consecutive cycles, and practically never for three consecutive cycles will she fail to have some vaginal bleeding. Even when scant flow appears, remembering that hypomenorrhea is common, she may develop presumptive symptoms of pregnancy and present herself for affirmation of its presence. One occasionally sees the individual who misunderstands the nature of cyclic medication or who has been incorrectly instructed to take her tablets continuously. As long as continuous medication is pursued, no mense occurs. This may ultimately be interpreted as pregnancy by the patient, especially so in light of the pregnancy-like symptoms that so often occompany use of the pills. Fortunately, where taken continuously, or correctly in cyclic fashion, pregnancy is so rare as to be dismissed from consideration.

A single exception occurs when ovulation and conception coincide with or immediately follow initiation of contraceptive therapy. It has been suggested that ovulation is inhibited

by as few as four (4) days medication, and is always inhibited by seven. Two situations are germane to this exception. The first occurs when the woman with 20 to 23-day cycles begins therapy. Ovulation occurs on the sixth to ninth days, or after less than four days of medication. The second takes place when therapy starts in the puerperal period, when the mother has not yet had a menstrual period, and there is no reference base for anticipating ovulation at all. Such patients should be instructed not to rely on this method for protection until the seventh pill is taken. At this point ovulation will have either already occurred, or will be suppressed. When pregnancy does occur its apparent gestational age is **greater** than the history suggests by about a week.

Irregular Bleeding

Breakthrough bleeding as a rule presents no problem as concerns pregnancy unless the patient discontinues medication in the face of it, either on her own, or on the physician's ill conceived advice. The number of menstrual patterns that might evolve are endless, but a case history well illustrates the point:

Mrs. J. C., 21-year-old para 1-0-1, took Enovid® 3 years. Withdrawal bleeding occurred December 25, 1964, and tablets were restarted December 30. Spotting began January 4, continued to January 10, when she voluntarily stopped medication. She had some pink discharge for five more days. On the 18th day of January and 19th of February no pregnancy could be recognized. On March 22 she was estimated to be only six weeks pregnant, although 9½ weeks had elapsed since the last vaginal bleeding, ten weeks since the last pill was taken, 11½ weeks since last vaginal bleeding began, and 13 weeks since the last normal withdrawal bleeding. Subsequent observation proved this to be a normal pregnancy and **not** a missed abortion. Ovulation apparently occurred about February 10, which did not correlate well with any of the historical facts concerning the pregnancy's onset. When medication is sporadic, the ovarian inhibition it maintains is ultimately escaped, and pregnancy may result. In the cited case pregnancy was a desired end, and the physician's only problem was correctly dating its duration.

Patterns After Cessation Of Therapy

It is well documented that conception rates following oral contraception are normal or even higher than normal! Furthermore, the vast majority of first spontaneous cycles are ovulatory[4,5] as measured by basal body temperature, estrogen-pregnandiol excretion curves, and endometrial biopsy. Mentioned occasionally,[2,3] but insufficiently underscored, is the frequency of prolongation of this first cycle. This is the result of an extended follicular phase, which lengthens the cycle by 7-14 days commonly, and infrequently to as many as 70 days. Ferin,[2] after ovarian inhibition with lynestrenol (17x ethinyl-2 deoxo-19 nortestosterone) found that the ovaries resisted stimulation from clomiphen citrate 100 mgm./day for 15 days, illustrating the degree to which the ovaries may be rendered insensitive after such a course of medication.

Interpretation of menstrual patterns after discontinuance of therapy is most important because it is most common. Some patients discontinue by choice, some by necessity, to use other contraceptive methods. Failure to resume spontaneous menses on schedule often triggers acute anxiety that pregnancy has occurred. All have read that the pills make pregnancy more likely after their use than before. Whether true or not, it is widely believed and the physician finds himself unable to make a positive diagnosis until the mense finally appears or pregnancy become readily recognized. This is true because at each negative examination or pregnancy test, ovulation and conception may have occurred only hours before.

Another case history is appropriate:

A 22-year-old para 3-0-0 had previous pregnancies terminate in stillbirth at 28 weeks, and neonatal death after delivery of a 32-week infant. Diabetes had been present for

four years. Oral contraception was voluntarily discontinued, with last withdrawal bleeding occurring on June 20, 1964. Spontaneous cycles were always regular and periods occurred at 28-day intervals. She was not seen in clinic until four and one-half to five months pregnant, at which time the duration of pregnancy was obscure. An examination by a private physician in early October allegedly revealed a ten-week gestation, which was two weeks less duration than the history indicated. On this basis and in the absence of distal femoral epiphyses on X-ray the first week of March, a diagnosis of delayed ovulation due to contraceptive pills prior to conception was made, and delivery was deferred two weeks to a re-estimated 37 weeks. A healthy infant was obtained, but lack of personal, critical, and accurate diagnosis of early pregnancy could easily have jeopardized this infant's life by causing its delivery at 35 weeks gestation rather than 37.

In diabetes, toxemia, elective induction of labor, postmaturity, and premature rupture of membranes and/or labor, this decision becomes of crucial importance in charting proper management of pregnancy. One may incorrectly suspect missed abortion on other occasions when the history and physical findings are inconsistent by a month or more. Further observation clarifies this situation as subsequent growth is demonstrated.

Summary

1. Effective management of many pregnancies demands precise prediction of the correct EDC or conceptive date.
2. Many menstrual patterns, especially of lengthened cycles or skipped periods, evolve in the use of oral contraceptives.
3. Because pregnancy and these menstrual aberrations are often by design or accident juxtaposed, the physician must be critical in his evaluation of them both.

References

1. Behrman, S. J.: Oral Contraception. Univ. Mich. Med. Cent. J. 30: 123, May-June, 1964.

2. Ferin, J.: Hypoestrogenic Amenorrhea and/or Sterility Induced by Lynestrenol. Int. J. Fertil. 9: 29-34, Jan.-March, 1964.

3. Mears, E.: Ovulation-Inhibitors: Large-Scale Clinical Trials. Int. J. Fertil. 9: 1-9, Jan.-March, 1964.

4. Peeters, F., Oeyen, R. and Van Roy, M.: Ovarian Inhibition With Progestogens: A Study Of The Recuperative Stage. Int. J. Fertil. 9: 111-120, Jan.-March, 1964.

5. Shearman, R. P.: Ovarian Function During And After Long-Term Treatment With Ovulation Inhibitors. Lancet 2: 557-558, Sept. 12, 1964.

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Evidence indicates that Lomotil acts directly on the intestinal musculature to inhibit excess peristalsis.

Lomotil is not known to inhibit nonpropulsive intestinal movements.

Roentgenograms demonstrate that this activity occurs within two hours after oral administration and persists for at least six hours.

Comparative studies in the rat show Lomotil to be more effective in inhibiting fecal excretion than either codeine or morphine.

Analgesic, anticholinergic, mydriatic and gastric secretory effects have not been significant.

Reduction of propulsive motility with Lomotil relieves spasm and cramping, allows physiologic absorption of fluid and reduces frequency of evacuations to provide prompt, symptomatic control of virtually all diarrheas.

LOMOTIL®

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)

atropine sulfate 0.025 mg.

tablets • liquid

slows propulsion



relieves distress



stops diarrhea



Precautions: Lomotil is an exempt narcotic preparation of very low addictive potential: more than three million prescriptions have now been written for Lomotil. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, *given in divided doses,* until diarrhea is controlled, are:

Children:

3 to 6 months—3 mg. (½ tsp.* t.i.d.)
6 to 12 months—4 mg. (½ tsp. q.i.d.)
1 to 2 years—5 mg. (½ tsp. 5 times daily)
2 to 5 years—6 mg. (1 tsp. t.i.d.)
5 to 8 years—8 mg. (1 tsp. q.i.d.)
8 to 12 years—10 mg. (1 tsp. 5 times daily)

Adults:

20 mg. (2 tsp. 5 times daily or
2 tablets 4 times daily)

**Based on 4 cc. per teaspoonful.*

Maintenance dosage may be as low as one fourth the therapeutic dose.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE *Research in the Service of Medicine*



PATHOLOGY FORUM

Supravalvular Aortic Stenosis And Facial Anomalies--- A Recently Described New Syndrome

By Ricardo Ceballos, M. D.

In general practice, aortic stenosis is a relatively infrequently encountered entity and previously associated with an ominous prognosis. Cardiac catheterization and aortography have made the diagnosis less difficult and the definitive diagnosis more frequent. Three major types of stenosis of the aortic valve region can be diagnosed: (1) subvalvular; (2) supravalvular, with or without internal webbing, and (3) valvular (most common).

In 1961, Williams, Barratt-Boyes, and Lowe[1] published a combination of clinical symptoms and signs which in their experience had led to the correct preoperative diagnosis on three occasions of supravalvular aortic stenosis, differentiating this form from the subvalvular and valvular types. The principal findings were: (1) usual clinical signs of aortic stenosis; (2) mental retardation—IQ (Stanford Benet) 42 to 72; (3) alterations of the soft tissues of the face including: (a) full face, (b) broad forehead, (c) wide-set eyes, (d) heavy dependent cheeks, (e) wide mouth, (f) pouting lips, and (g) pointed chin.

The recognition of this apparent syndrome should facilitate the ability of the clinician to correctly diagnose, preoperatively, the supravalvular variant of stenosis of the aortic valve region. After the original contribution this syndrome has been recognized in a variety of occasions by German [2, 3] and American writers.[4] Combined with consistently improving surgical techniques, affected persons, previously undiagnosed and without treatment, may be helped.[13-15]

II. CASE REPORT—A single case is now reported. This mentally retarded 10 year old white male was the product of an uncomplicated pregnancy and weighed 5 pounds 12 ounces at birth. The mother purported that the pediatrician detected a heart murmur in the immediate postnatal period. The child attended a school for retarded children and functioned at the level of the first and second grades. The child had had no cyanosis or clubbing, but had been less well coordinated than other children his age and through the years had had decreased exercise tolerance. His grandmother states that he had only recently learned to ride a bicycle and could not ride it around the house more than two to three times without tiring. The child's physical development had been poor, lying below the third percentile in height and weight on the anthropometric chart

From Department of Pathology, The University of Alabama Medical Center.

of the Children's Medical Center, Boston, Massachusetts.

Referred to University Hospital on February 26, 1963, for definitive diagnosis and treatment of the suspected congenital heart lesion, the child underwent cardiac catheterization and aortography. A systolic left ventricular pressure of 170 mm. of mercury was found in contrast to an aortic pressure of 100 mm. of mercury systolic. Aortography demonstrated the supravalvular position of the stenosis. A two month interim elapsed between the diagnosis and final admission for elective surgery, during which the child experienced vague chest pain considered clinically to be insignificant.

On April 15, 1963, examination on admission to University Hospital for elective surgery revealed a small sized, well-developed child weighing 54 pounds (average 72 pounds) and measuring 51 inches (average 57 inches) in height. Various observers described the face as being "monkey-like," having a "wide ridged nose," "simple expression," and resembling a "Mongoloid" individual. A systolic thrill was palpable over both carotids. A grade III to VI systolic murmur was heard loudest over the P2 area. The precordium was visibly active. Blood pressure was 105/70 mm. Hg. Pulse was 100/minute and regular. Respiration was 20/minute and regular. The lungs were clear to auscultation and percussion. The liver was palpable two finger breadths below the right costal margin.

Finding no contraindications, the child, under general anesthesia, was placed on cardio-pulmonary bypass with extracorporeal circulation. The chest was entered through a median stenotomy incision. A lateral aortotomy incision was made in the area distal to the stenosis and revealed an extremely narrowed outflow tract, estimated surgically to be 0.5 cm. in diameter. Extending the incision proximally was complicated by the stenotic area blocking the view of the aortic cusp. It was necessary to incise the aorta down into the aortic valvular sinus to relieve the stenosis. A pear-shaped Teflon patch approximately 4 cm. in length and 1.5 cm. in width was sutured by continuous suture into the aortic incision. The period of aortic occlusion was 24 minutes. The left ventricular pressure at the conclusion of extracorporeal profusion was 100 mm. of mercury systolic and no thrill was palpable in the outflow tract. Approximately three hours postoperatively, the patient developed a sudden ectopic rhythm characterized by a change from a sinus to a nodal rhythm. The blood pressure fell. The chest was reentered to relieve a suspected tamponade. No evidence of tamponade was found, however, the heart was observed to fibrillate. After a period of cardiac massage, the patient was defibrillated with single DC shots on five occasions. A normal sinus rhythm was restored after 40 minutes. The child expired ten hours postoperatively in a second bout of ventricular fibrillation, clinically considered secondary to insufficient coronary perfusion.

The post mortem examination was unfortunately limited to the external examination and the removal of the thoracic viscera. The ten year old white male, despite proportioned development, appeared no larger than an eight year old child. The brachycephalic head had dense black hair with a low hairline on the forehead. The face was full with prominent cheeks and a wide mouth. The lips were slightly averted as if pouting. The chin contrasted with the well-rounded contours of the face by being relatively pointed (Fig. 1). A 23 cm. median stenotomy incision had been closed by a run-



Fig. 1. Characteristic facies.

ning black silk suture after the terminal open chest resuscitative measures. The abdomen was flat and free of palpable masses. The usual cutdown sites and chest tube openings were noted. There was no edema or jaundice. The external genitalia were prepubertal male. Inguinal hernias were not present. On opening the thorax, focally atelectatic lungs, a mild bilateral serosanguinous hydrothorax, and the anticipated traumatic fibrinous pericarditis were found. The diffusely hypertrophied 210 gram heart had a moderate amount of subepicardial fat. A Teflon patch was visible in the right postero-lateral wall of the ascending aorta. The hypertrophied ventricular walls measured 1.7 cm. on the left and 0.8 cm. on the right. The various heart chambers were free of premortem thrombi. Focal endocardial hemorrhage was present in the sutured right atrium. All heart valves including the aortic valve were normally formed, thin, and delicate.

Lying less than 0.5 cm. above the aortic ring was an irregular confluence of endothelial-covered nodules reducing the circumference of the 2.2 cm. ascending aorta to 1.5 cm. (Fig. 2).

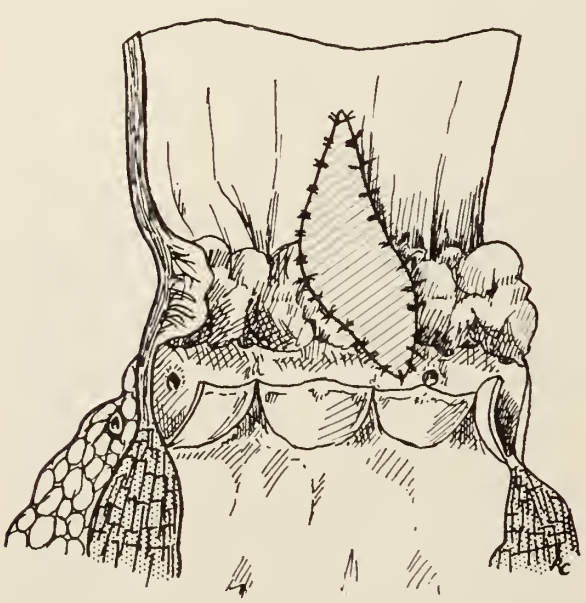


Fig. 2. Ring of nodular prominences stenosing the aorta above the valve. Teflon patch in place, close to the ostium of the right coronary artery. Schematic.

No web was present across the outflow tract. Proximally the circumferential lesion did not involve either of the normally positioned coronary ostia or the delicate aortic valves. The arch of the aorta gave rise to a persistent right subclavian artery. Distally the ascending aorta was only minimally dilated to a circumference of 2.4 cm.

Despite their normal position, the coronary arteries were not without affliction. The right ostium was small with a relatively thick wall. There was no atheroma or occlusion demonstrated. The main trunk of the left coronary artery had only a narrow slit for a lumen with a disproportionally thickened wall. The left circumflex coronary artery was patent but the anterior descending coronary artery had a 1 cm. in length segment with a thick wall and a pinpoint lumen.

The microscopic examination of the lungs and myocardium were not contributory. Full thickness longitudinal sections of the constricting supravalvular aortic rind were studied with the routine Hematoxylin and Eosin stains and other appropriate special stains. These sections showed a hypertrophied media, thickened to at least twice that of a normal aorta. The elastic tissue pattern immediately adjacent to this stenotic area was disrupted with the fibers bending at right angles and pointing into the stenotic area. Superimposed on this area of medial hypertrophy was a prominent sclerotic mass of homogeneous collagen. This was covered by an intact endothelium with the exception of a few areas of traumatic abrasions. In the stenotic area, Verhoff-van Gieson stains revealed moderately widened bands of fibrous tissue which extended peripherally to entwine between normally oriented medial components of elastic tissue and smooth muscle. Multiple sections of this stenosis failed to reveal either inflammatory infiltrate or Aschoff type structures. No degeneration or medial necrosis was noted (Fig. 3 and 4).

The left coronary artery was 80 per cent occluded by eccentric intimal proliferation. The left circumflex coronary artery had an eccen-



Fig. 3. Section of aorta and base of stenotic ring. Elastic fibers from aorta (lower left) enter the nodule and eventually melt into connective tissue caps (right side). Verhoef-Van Gieson (10 x).

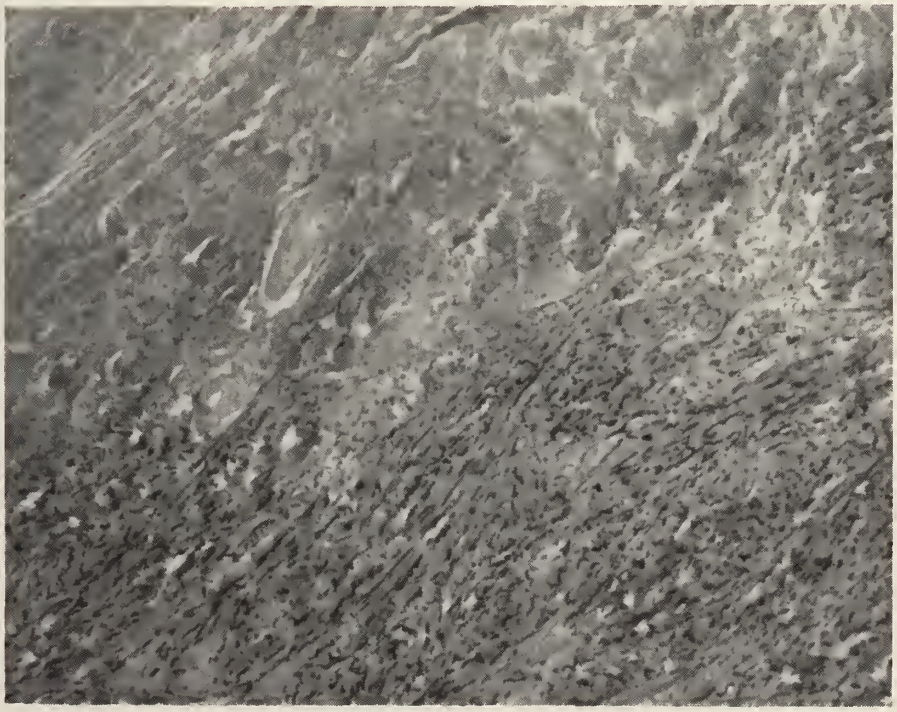


Fig. 4. Detail of above. Area of transition between elastic rich tissue and collagenous areas. Verhoef-Van Gieson (40 x).

tric lumen secondary to medial proliferation. The left descending coronary artery had a slit-like lumen due to intimal proliferation. The right coronary artery showed mild intimal and eccentric medial proliferation (Fig. 5 and 6).

III. DISCUSSION: In the formation of the aortic area, a spiraling septum divides the truncus arteriosus and extends farther to form the membranous portion of the interventricular septum. Simultaneously, adjacent nodules at the level of the aortic ring persist and are fashioned into delicate valve leaflets. If the timing of this process is altered or the molding is incomplete, malformed valves and webs cross the narrowed outflow tract and stenoses persist in the adult form.

Supravalvular aortic stenosis represents such a fault. Alterations in the septum dividing the truncus arteriosus, early abortive attempts at valve formation or simply persistence of mesenchymal nodular masses may account for the untimely narrowing of the aortic outflow tract. This supposition is supported by a comparison of the microscopic appearance of the stenotic area and a valve leaflet. A valve leaflet is initially quite cellular and only with time becomes acellular, avascular, with a dense homogeneous collagen remaining. The stenotic area in this case is an acellular, avascular mass of endothelial lined collagen attaching itself to normally oriented aortic media.

As suggested by one of the clinial examiners in this case, the facial alterations are similar in basic character to those seen in Mongolism which is frequently associated with interventricular septal defects. The apparently sporadic appearance of the supravalvular aortic stenosis among families free of heart disease parallels the appearance of Mongolism in previously unaffected families. With the genetic abnormality in Mongolism well-documented (Trisomy 21-22), one wonders of a similar genetic abnormality appearing in these cases. Soft tissue molding of the face and the formation of the heart septa and valves occur between the sixth and 12th weeks of gestation and are, in a vague way, related since they represent simply "finishing touches" in mesenchymal derivatives. It is unfortunate that chromosomal studies were not performed in this case. However, similar thoughts about these cases have already prompted four different investigators[5] to study the chromosomal pattern on a total of a dozen cases. All have produced negative results. These negative results should not hinder further genetic inquiry since not all chromosomal aberrations have necessarily to reflect themselves as ideogram alterations recognizable with the means at our disposal today.

The importance of this case lies in its support of the syndrome proposed by Williams, Barratt-Boyes, and Lowe and corroborated by others.[2-5] Despite the dissimilar findings, the similarities are overwhelming. Dissimilar findings in the heart are minimal. In the four cases reported by Williams, Barratt-Boyes and Lowe, none had a heart murmur detected until later in life. Other reported cases have had it. In our case, the mother reported a murmur to have been present since the neonatal period. In one of the cases reported by Williams, Barratt-Boyes, and Lowe, the coronary ostia were at different levels; a single web was produced in another; the aortic constriction was immediately adjacent to the aortic commissure in another; subvalvular muscular stenosis was also evident at surgery in another but this muscular stenosis was considered secondary to left ventricular hypertrophy, and was not altered surgically. All these appear as minor variations in a basically consistent primary malformation.

Black and Bronham Carter[6] in 1963 attempted to correlate the picture of aortic supravalvular stenosis in older children to the recognized syndrome of hypercalcemia of young children (Fanconi et al,[7] 1952). Based on animal experiments [8, 9, 10, 11] in which induced hypervitaminosis D and secondary hypercalcemia produced aortic sclerosis in the rat and rabbit "just above the aortic sinus," Garcia, Friedman, Kaback and Rowe[12] reported a child with "elfin" appearance in whom aortic supravalvular stenosis and hypercalcemia were found simultaneously at age nine months. Mild pulmonary valvular stenosis complicated their case. Williamson,[4] however, reported a typical case



Fig. 5. Left descending coronary. Slit-like lumen due to extreme hyperplasia of intima and arteriosclerosis. Hemotoxylin-Eosin (10 x).

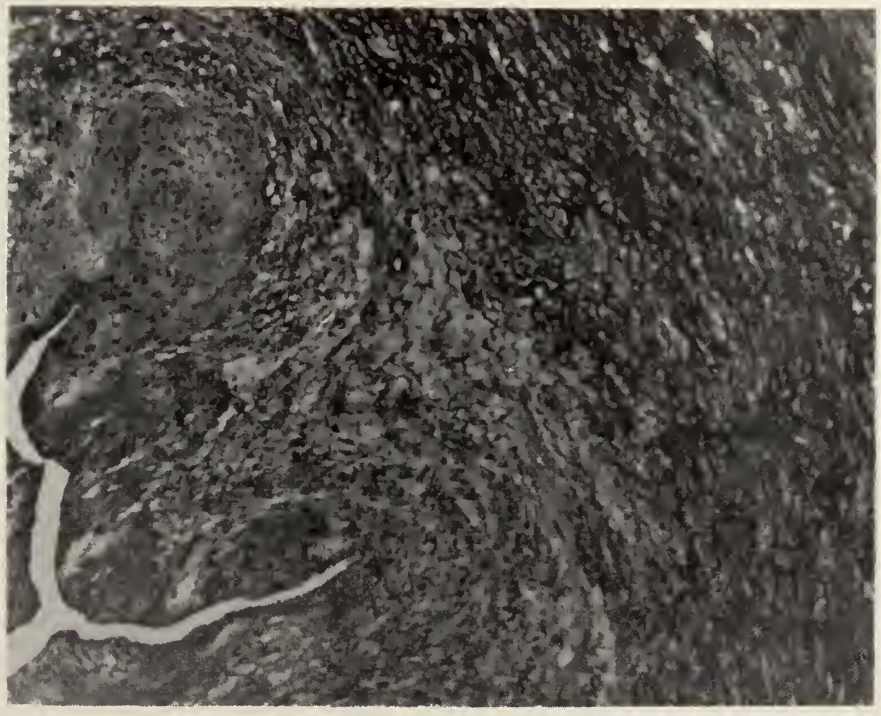


Fig. 6. Right coronary. Small irregular lumen, with intimal proliferation and hypertrophic media. Verhoef-Van Gieson (40 x).

of supravalvular stenosis syndrome and found no new evidence to support the suggestion that these children are survivors of the severe infantile hypercalcemia.

It is our opinion that the etiology of this disease will be proven to be chromosomally-linked and most likely not associated to any significant degree with the infantile hypercalcemia.

While not seen in cases of valvular and subvalvular stenosis, the intimal and medial hyperplasia of the coronary ostia constitutes an important difference. This combined hyperplasia is assumed secondary to the increased pressure caused by the aortic stenosis. The cause and effect relationship is similar to that accepted in the Eisenmenger's complex which produces pulmonary hypertension with secondary intimal and medial hyperplasia of the muscular pulmonary arteries. Lending support to this is the observation that the four cases of Williams, Barratt-Boyes, and Lowe, while not showing this complication, had a pressure gradient of only 38 mm. of mercury in their oldest child, age 12.

This combined hyperplasia may severely reduce the coronary lumen. Following surgical correction, with removal of the pressure gradient, the aortic pressure becomes normotensive and coronary profusion through the reduced lumen may drop precipitously. Such hyperplastic changes when advanced are therefore not compatible with normotensive life. Despite the fact that surgical intervention may preferably be delayed beyond early childhood to permit the heart and aorta to approach more adult proportions, the presence of a marked stenosis, determined by an elevated pressure gradient (70 mm. of mercury) may be a justifiable indication for earlier surgery. Certainly the diagnosis of supravalvular stenosis does not produce the surgical urgency that, for instance, a diagnosis of Wilms tumor of the kidney demands, but the presence of a high gradient across the stenosis should remind both the pediatrician and the surgeon of its ominous effects on the coronary artery.

Many of the non-cardiac features in the cases of Williams, Barratt-Boyes, and Lowe and the others coincide with our case. The mother was well during pregnancy. The child had remained below average height and weight throughout life. The mental retardation was evident from his performance at the first and second grade level. The facial resemblance derived from soft tissue similarities are documented by figure 1. The face was full; the forehead broad; the eyes set well apart; the cheeks were heavy and dependent; the mouth was wide with pouting lips; the chin was pointed. Like in one of the reported cases, malocclusion of the teeth was also present. The patient had five younger siblings. They shared certain family features but none had the distinctive facial characteristics this child had. No family history of heart disease is present. The blood lines of the mother and father are dissimilar.

IV. SUMMARY: The case of a ten year old white male is presented with the gross and microscopic autopsy findings which correspond well with those features proposed by Williams, Barratt-Boyes, and Lowe, to permit the preoperative clinical diagnosis of circumferential supravalvular aortic stenosis. The Williams, Barratt-Boyes and Lowe syndrome is composed of: (1) usual clinical signs of aortic stenosis; (2) mental retardation; (3) soft tissue similarities of the face including—(a) full face, (b) broad forehead, (c) wide set eyes, (d) heavy dependent cheeks, (e) wide mouth, (f) pouting lips, and (g) pointed chin. This additional case supports their conclusions. Their syndrome represents a significant contribution in the advancement of the clinical approach to a patient with the usual signs and symptoms of stenosis of the aortic valvular region. The striking similarities between this syndrome and Mongolism suggests a chromosomal aberration etiology, which so far has not been demonstrated.

The intimal and medial hyperplasia induced by the prolonged elevated left ventricular pressure, if advanced, is incompatible with normotensive life. Earlier surgical attention may be necessary in aortic stenosis of the supravalvular type.

(See Page 115 for Bibliography)

Bibliography

1. Williams, J. C. P., B. G. Barratt-Boyes, and J. B. Lowe. 1961. Supravalvular Aortic Stenosis. Circulation. 24: 1311-1318.

2. Beuren, A. J., C. Schulze, P. Eberle, D. Harmjanz, and J. Apitz. 1964. The syndrome of supravalvular aortic stenosis, peripheral pulmonary stenosis, mental retardation and similar facial appearance. Amer. J. Cardiol. 13: 471-483.

3. Beuren, A. J., J. Apitz, and D. Harmjanz. 1962. Supravalvular aortic stenosis in association with mental retardation and a certain facial appearance. Circulation. 26: 1235-1240.

4. Williamson, D. A. 1964. Supravalvular aortic stenosis associated with mental and physical retardation and a characteristic facies. Proc. Roy. Soc. Med. 57: 118-119.

5. Eberle, P. and A. J. Beuren. 1963. Chromosome studies in patients with supravalvular aortic stenosis. Lancet 2: 438.

6. Black, J. A. and R. E. Bonham Carter. 1963. Association between aortic stenosis and facies of severe infantile hypercalcoemia. Lancet 2: 745-748.

7. Fanconi, G., P. Girardet, B. E. Schlesinger, N. R. Butler and J. A. Black. 1952. Helv. paediat. acta. 7: 314.

8. Gillman, J. and C. Gilbert. 1956. Calcium, phosphorus and vitamin D as factors regulating integrity of cardiovascular system. Exper. Med. and Surg. 14: 136-168.

9. Vanderveer, H. L. 1931. Hypervitaminosis D and arteriosclerosis. Arch. Path. 12: 941-955.

10. Hass, G. M., R. E. Trueheart, C. B. Taylor and M. Stumpe. 1958. Experimental histologic study of hypervitaminosis D. Am. J. Path. 34: 395-431.

11. Eisenstein, R. and L. Zeruolis. 1964. Vitamin D-induced aortic calcification. Arch. Path. 77: 27-35.

12. Garcia, R. E., W. F. Friedman, M. M. Kaback and R. D. Rowe. 1964. Idiopathic hypercalcemia and supravalvular aortic stenosis. New Eng. J. Med. 271: 117-120.

13. McGoon, D. C., H. T. Mankin, P. Vlad and J. W. Kirklin. 1961. The surgical treatment of supravalvular aortic stenosis. J. Thoracic Surg. 41: 125-133.

14. DeBakey, M. E., and A. C. Beall, Jr., 1963. Successful surgical correction of supravalvular aortic stenosis. Circulation. 27: 858-863.

15. Gordon, A. S. 1962. The surgical management of congenital supravalvular, valvular, and subvalvular aortic stenosis using deep hypothermia. J. Thor. Cardiov. Surg. 43: 141-156.

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REVIEW AND OUTLOOK

THE DOCTOR'S DILEMMA

As a conscientious, public-spirited individual, suppose you are given a choice of two alternatives. Either you can take part in a program which you believe is contrary to the nation's interest. Or you can abstain from the program and, by so doing, quickly make it worse.

That, essentially, was the dilemma that confronted representatives of the medical profession when they assembled in New York City recently to consider an approach to medicare, the program of health care for the aged that Congress now appears all but certain to pass. In their attitude toward the matter, most doctors seem more responsible than the politicians.

The medical men, like the politicians, recognize that many of the nation's elderly cannot pay for all the health services they need. Though they agree on the problem, the doctors quite correctly are highly dubious of the politicians' "solution": Forcing nearly everyone who works to pay taxes to finance a limited package of benefits for all over-65 Americans, whether they actually need any such Governmental help or not.

Behind this unquestioning largess is the theory that it would be somehow degrading to find out whether older people need Federal aid. But the hypocrisy of that argument must have been evident the other day when the Senate Finance Committee, in okaying medicare, also voted to permit the aged to earn up to $1,800, instead of $1,200, without forfeiting part of their regular Social Security benefits; it seems the Government already is in the "degrading" business of eyeing the incomes of the elderly.

Unnecessary costs and complications are only a portion of the case against medicare. Even more worrisome is the fact that, like all foot-in-the-door Federal programs, it is practically certain to become immensely more expensive and complex.

If political muscle can be mustered to provide limited benefits for everybody over 65, it can also be furnished to make the benefits much less limited. Sooner or later, a lot of people also are going to be arguing that the age limitation is discriminatory. If a well-to-do 65-year-old gets benefits he doesn't need, why rule out someone who is unlucky enough to be only 60? Or 50? Or 40? Constant "liberalization" is the history of Social Security.

Once the principle is firmly rooted in the

law, in other words, it builds up relentless pressure for expansion. And anyone who thinks that a government can run an efficient, thriving national health service hasn't noticed the current mess in Britain or the prodigious incompetence our own Government displays in many of its existing welfare efforts.

It's perfectly understandable that many doctors would rather have no part in such escalating chaos. But if doctors did, in fact, refuse to participate, it would mean that all of the rules and regulations would be written by bureaucrats who are ill-informed, however well-intentioned, without benefit of the counsel of the specialists in the field. Without intelligent control, in turn, the costs and convolutions of the vast venture would be sure to multiply still more rapidly.

The refusal of some doctors to take part, moreover, would not prevent politicians from swiftly enlarging the program. Indeed, many of them are likely to realize quickly enough that if they can force millions of people into a health program they certainly can compel a few thousand doctors to go along with any ballooning scheme they draw up.

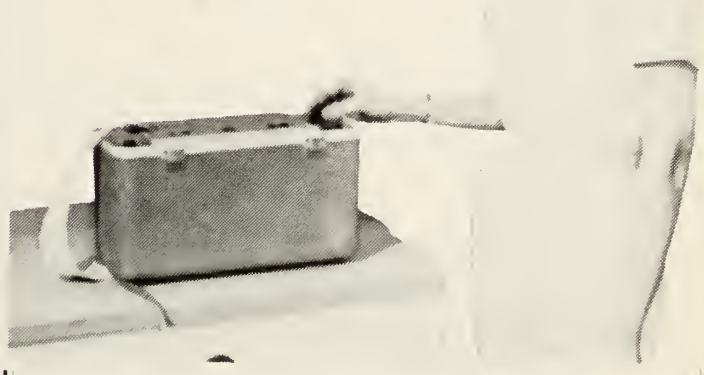
In the doctor's unfortunate dilemma, most of them seem to be steering a sensible course. Though some continue to talk of "strikes" or "boycotts" against medicare, there was little support for such action from the leadership at the meeting of the American Medical Association's House of Delegates. On the contrary, while in no way weakening in their opposition to the program, AMA leaders offered to confer with Administration officials in an effort to remove some of its more patent flaws.

The members of the medical profession cannot be expected to make a silken satchel out of a politician's ear, but they might be able to help make medicare half-way manageable—and perhaps do some preventive surgery against monstrous future growth.

Reprinted from the *Wall Street Journal*, July 1, 1965.

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HOUSE JOINT RESOLUTION NO. 34

By Mr. Brown (Tuscaloosa).

WHEREAS Dr. Rufus Cornelius Partlow, assistant superintendent of Partlow State School and Hospital, will retire on July 31, 1965, after having served a total of fifty-three continuous years in the administration of Alabama State Hospitals, thirty years having been at Bryce Hospital, two years at Searcy Hospital, and twenty-one years at Partlow State School and Hospital; and

WHEREAS Dr. Partlow, who was born at Asheville, graduated from Howard College and Birmingham Medical College, has long been recognized by members of his profession as an outstanding physician with exceptional qualifications. His abilities as a physician and administrator, combined with his humanitarian qualities have made his services invaluable to this state and particularly to the patients cared for in its institutions. Through his constant effort and dedication, he has not only greatly improved the care and treatment of the patients under his charge, but he has made possible an increase in the number who are benefited by Partlow State School and Hospital; now therefore

BE IT RESOLVED BY THE LEGISLATURE OF ALABAMA, BOTH HOUSES THEREOF CONCURRING, That the members of the Legislature express their grateful appreciation to Dr. Partlow and commend him for his outstanding services to our state during his long and distinguished medical career, and extend to him their best wishes for his continued success upon his retirement.

BE IT FURTHER RESOLVED that copies of this resolution be sent to Dr. Partlow, to The Medical Association of the State of Alabama, and to the Tuscaloosa News.

Adopted by the House of Representatives June 11, 1965

Concurred in and adopted by the Senate June 18, 1965

Approved by the Governor June 28, 1965

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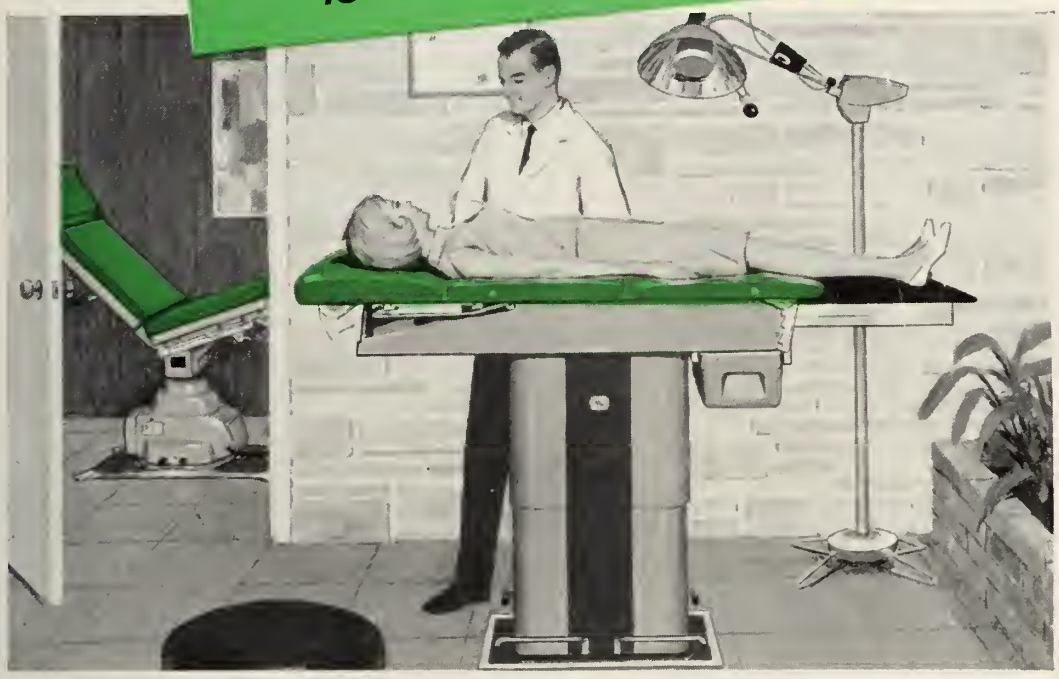
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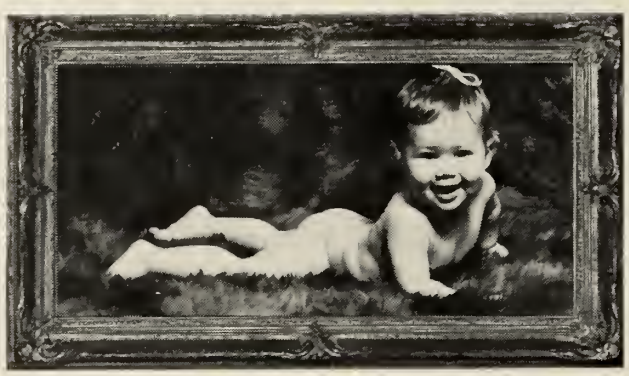
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1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. *8*:73-77 (Jan.) 1957

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*Swartz, C., et al.: Circulation 28:1042, 1963.

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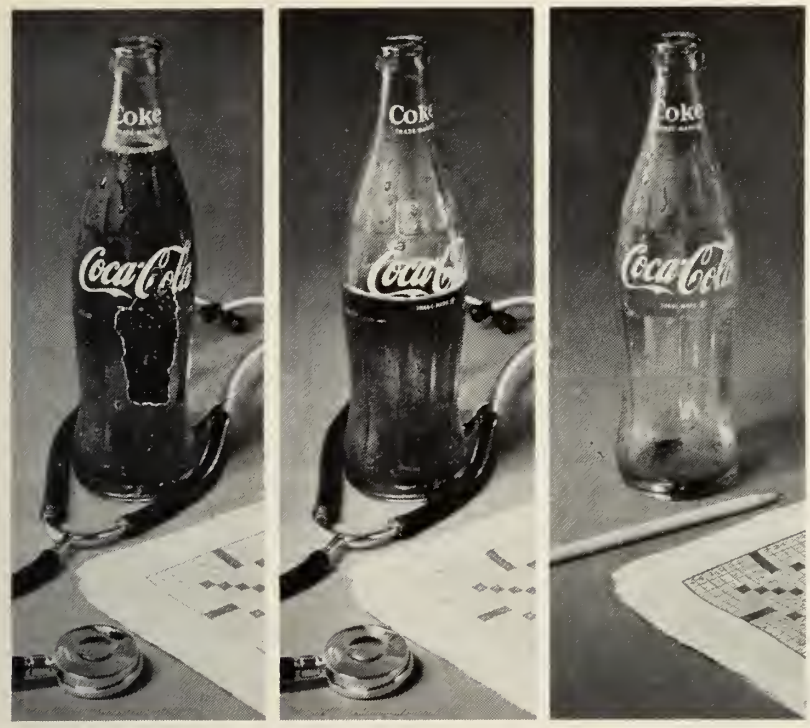
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The Woman's Auxiliary



Our 42nd Annual Convention of the Woman's Auxiliary to the American Medical Association held at New York's Americana Hotel June 20-24, was attended by more than 1,100 members and 500 children. I would like to give you a round-up report and to thank our President-elect, Mrs. Ira Patton for filling in for me since I was in the hospital. Our other delegates who so faithfully attended all the meetings were Mrs. William L. Smith of Montgomery; Mrs. John Kimmey of Elba; Mrs. William G. Thuss of Birmingham; and Mrs. M. Vaun Adams of Mobile.

Presentation of $320,121.87, of which Alabama contributed $10,045.08, was the Auxiliary's annual contribution to the American Medical Association Education and Research Foundation. I think you husbands should be very proud of your wives for raising all of this money. Six state auxiliaries received awards of merit for raising the largest amount in their membership categories. They were: Nevada; Maryland; Tennessee; Louisiana; Indiana, and California.

A citation for "exceptional services to the nation's handicapped" was presented to the AMA Auxiliary from the President's Committee on Employment of Handicapped. Committee Chairman Harold Russell also presented a citation to the Dade County, Florida, Auxiliary for its outstanding contributions in this area. The Florida group also nominated the winner of a special committee award, Miss Rhea Dina Lemerman of Miami.

Mrs. William G. Thuss, past national president, installed Mrs. Richard A. Sutter as president on June 23. In her inaugural address she urged doctors' wives to participate in action programs on public problems, coordinated with other agencies and organizations, working at local, state, and national levels. Other officers installed were Mrs. Asher Yaguda, president-elect; Mrs. C. C. Long, first vice president; and Mrs. Erle E. Wilkinson of Nashville, Tennessee as our Southern Regional Vice President. The new Treasurer is from Honolulu, Hawaii, Mrs. Howard Liljestrand.

An amendment of the By-Laws was made changing the composition of the Board of Directors. The Board shall now consist of the elected officers, immediate past president and the finance secretary, historian and chairman of the Committee on By-Laws. The latter three serve exofficio, non-voting members.

We are very proud of Mrs. John Chenault of Decatur, Alabama being elected to serve on the 1965-66 Nominating Committee.

Eloise Bryant Crenshaw

Mrs. James F. Crenshaw

Alabama Department of Public Health

Family Planning In Alabama

Harold Klingler, M. D., Director

Bureau of Maternal and Child Health

It seems that we are in an era of gadgets and gimmicks. Family planning methods are no exception to this situation. I speak particularly of the different types of intrauterine devices.

An apartment house builder from Los Angeles recently told me that in order to rent and sell apartments it is necessary to install all sorts of gimmicks and gadgets, including swimming pools with pool-side telephones, intercom systems, piped-in music, air conditioning, dishwashers, and many others. I wonder if the publicity recently offered contraceptive devices may not be a factor in the impetus given family planning over the past few years.

Speaking of gimmicks, this one in particular is amusing. In Los Angeles, where there is an acute parking problem, car bumper stickers are used on which is printed in large red letters:

"Difficulty Parking?—Support Planned Parenthood"

It is likely that such a gimmick offered more assistance in fund raising than did a lot of talk about the population explosion.

The Alabama story is interesting. This state is a pioneer in family planning, which is simply called "spacing" in this area.

In 1930 a nurse from Alabama was sent to the Margaret Sanger Clinic in New York. On the first day of her clinic attendance a patrol wagon drove up, whisked Margaret Sanger to the police station, and charged her with dispensing contraceptive materials and information which was illegal in that city. New York has come a long way since that time, but it is interesting to note that not until 1957 did Bellevue Hospital have a spacing clinic.

In the early 1930's a Birmingham physician described a pitiful situation he had observed at the Children's Hospital to a colleague, a gynecologist. He said, "If there ever was a woman who should know how to plan her family it was one I saw this morning at the free clinic." He described her as a bedraggled young woman with a sick baby in her arms. Clutching to her skirt was a child of two years, and it was quite evident that she was going to have another child very soon. The gynecologist told the pediatrician to send her to his office after her third child was born,

and he would give her advice and fit her with a diaphragm.

The pediatrician later attended a class reunion at Harvard, where he told his story. A classmate donated $50.00 for material with which to start a clinic for family spacing. This was really the origin of planned parenthood in Alabama.

A meeting was held in a local church, and the first clinic opened at the old Hillman Hospital. Permission for operation of such a clinic was overlooked, and a few months later when a board member discovered this activity the clinic was promptly closed.

The path of the pioneers in this movement was not always rosy. It is good that men and women with foresight and fortitude were consistent and firm in their convictions to the extent that they continued their work in the face of considerable adverse criticism.

Later, the Tuberculosis Association of Birmingham invited the clinic to meet in their building, which was an old remodeled residence on 6th Avenue near Hillman Hospital. Activity continued at this location for some time.

In 1937, the American Medical Association approved family planning. The Alabama State Board of Health offered similar approval in 1938 by unanimous vote. This approval was largely due to the efforts of the Birmingham gynecologist. The state Bureau of Maternal and Child Health incorporated this service on a state-wide basis immediately thereafter.

The attitude of the Bureau of Maternal and Child Health of the State Health Department is that child spacing is for only one purpose: to improve the health and well-being of mothers and babies. We are neither economists nor sociologists. Spacing is simply a part of our complete maternity care program and but one facet of service offered in the care of indigent mothers. Our spacing services are operated by and offered only at our post-partum clinics. The Bureau of Maternal and Child Health has always worked in close co-operation with Planned Parenthood.

Family planning has come a long way in Alabama over the past two decades due to the efforts of many individuals and organizations. Shortly after the State Board of Health approved family planning, several industries in the state approved funds for spacing for their employees. Two of these were Avondale Mills and the W. T. Smith Lumber Company. A drug company in the middle '40's offered spacing materials and other assistance in a research program which continued for several years.

Spacing, however, did not gather great momentum until about four years ago. Since that time the case load has doubled. At the present time about 10,000 indigent patients are offered service through the facilities of the State Health Department.

Many philanthropists are interested in this area of endeavor. Recently a grant was accepted from the Sunnen Foundation for hiring of personnel and materials for family planning through the generosity of Mr. Joe Sunnen of St. Louis.

The socio-economic groups of patients we see at our clinics are difficult to motivate in the use of contraceptives. For that reason, failures are likely to occur. At the present time, in co-operation with the University of Chicago and under the direction of Dr. Donald Bogue, Professor of Sociology, a motivation study is being conducted in 13 of our Black Belt counties. This activity is supported by grants from the population council. Funds to this council are made available through appropriations from the Ford and Rockefeller Foundations. This study offers health educators and spacing materials for use in this study group.

Many methods of prevenception have come and gone over the past several years. At present our methods consist chiefly of five: (1) foam preparations; (2) the pill; (3) rhythm; (4) surgical sterilization; and (5) most recently, the intra-uterine contraceptive device.

It is our feeling that these different methods should not be offered our clientele on a free choice, cafeteria-type selection. It is more practical in our type of patient for the physician to identify the type that he feels will operate most efficiently in the individual case. At the present time the pill routine is the method most frequently used.

The intra-uterine contraceptive device is the most recent addition to our armamentarium, and is now available in 15 counties. This method offers advantages in several respects. First, motivation is not an important factor; second, the device is placed and, with the exception of occasional follow-up, the method is in operation; third, it is less expensive than other methods. At first we were quite reluctant to use a method involving the use of a foreign body in the uterus—a hold over from the memory of the old Grafenberg ring and the stem pessary days. The use of both devices is now condemned. Statistics indicated the use of the polyethylene intrauterine device to be innocuous. Our findings coincide completely. We have used only the large Birnberg bows and the large Lippes loops. It is our finding that failure occurs in about ten per cent of insertions due to fall-out, pain, bleeding, and pregnancy. At the present time about 1,000 of these devices have been inserted. We do not recommend the use of this contraceptive device in nulliparous patients due to technical difficulties sometimes encountered in placement.

We first used the steroid pill in 1962. In 1964, 20 times as many pills were used as were used in 1963. No major complications have occurred in any of our methods of prevenception.

Prevenception advice and materials are available in each of the 67 counties of the state, and in many of these counties there is considerable activity with 230 clinics in operation.

Birth rates throughout the nation have been decreasing since the peak rate in 1947. The national birth rate for 1963 was 21.1. For Alabama during the same period the rate was 22.4. However, it is interesting to note that the white birth rate in Alabama in 1963 was only 20.1 as compared to the national rate of 20.7.

The non-white birth rate for Alabama was 27.9, as compared to 29.7 for the national rate.

Thus, it is seen that both our colored and white birth rates are lower than the national average.

In the past ten years the colored birth rate has been reduced from 32 to 27.4, and the white from 23.5 to 20.1. The colored birth rate has been reduced 4.6 and the white rate reduced 3.4.

It is estimated that the cost to the taxpayers is some $2,500 for each child on the aid to dependent children program. It is felt that, although the economic assistance offered by a spacing program is certainly to be considered, we must also remember that high-risk, unwanted babies are prevented by a family planning program.

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Dosage
The initial daily dosage in adults is 300-600 mg. in divided daily doses. In most instances, 400 mg. daily is sufficient for maximum therapeutic response. A trial period of one week is adequate to determine the effects of the drug; if there is no improvement, discontinue the drug. When improvement does occur, dosage should be promptly decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning: If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Side effects
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Contraindications
These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient cannot be seen regularly, when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin® alka are contraindicated in patients with glaucoma.

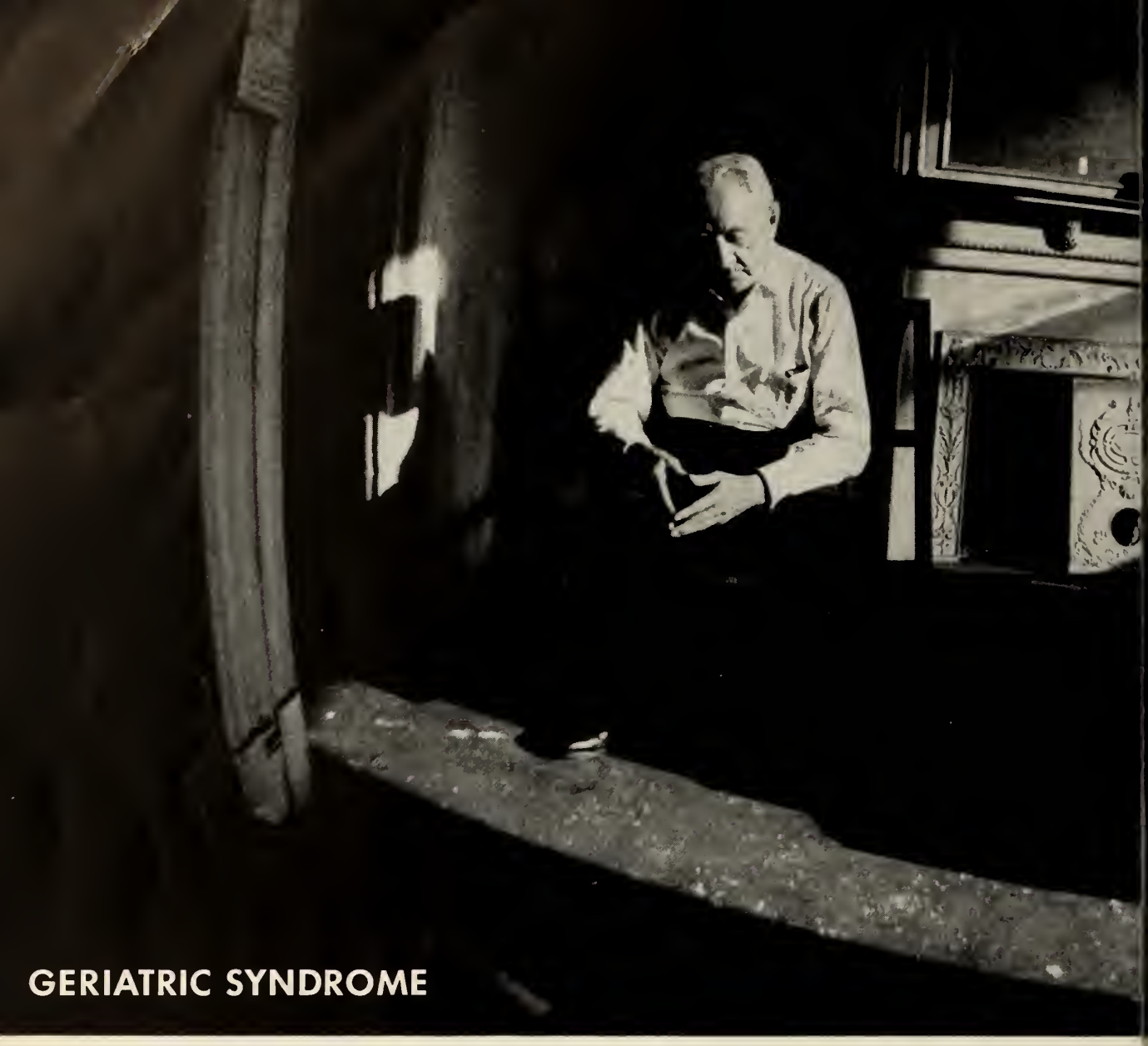
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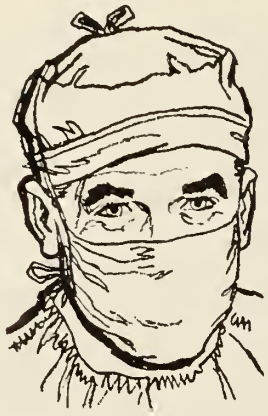
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Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal of hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

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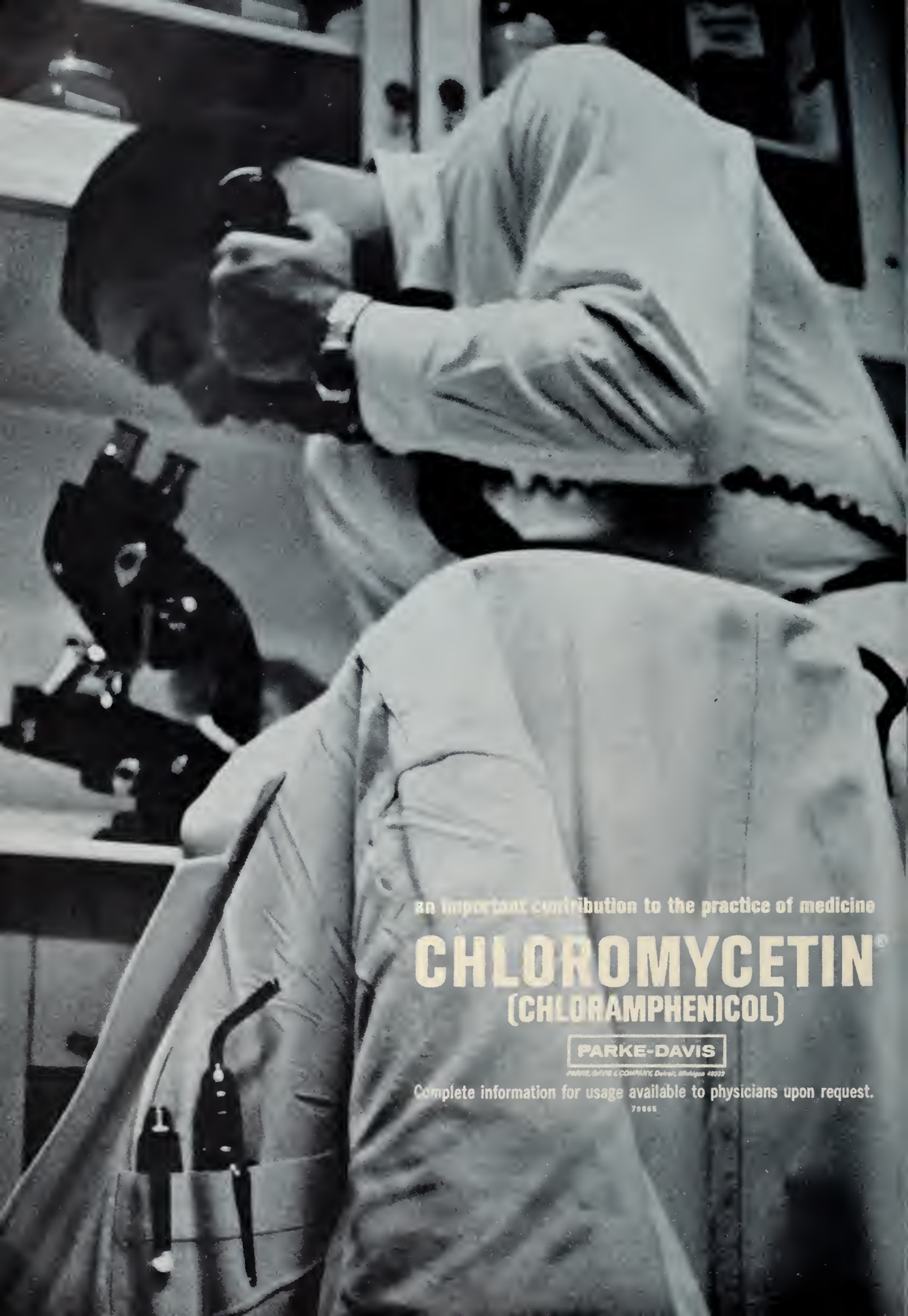
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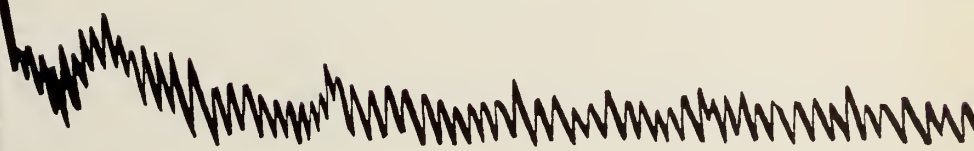
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of the

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President's Page



Now that H. R. 6675, the "Medicare" Bill, has been passed by both houses of Congress and dramatically signed into law by the President, members of the medical profession must decide how best to proceed. Some have vigorously proposed the view that the only proper course to follow is that of total non-participation in any part of the law. Others, including the President of the AMA, have expressed the opinion that, in spite of opposition to the law, it is the duty and obligation of physicians to participate in the intent of the law and try to influence the rules and regulations as favorably as possible. The House of Delegates established the present policy of the American Medical Association to be as follows:

(1) It is the obligation of each individual physician "to decide for himself whether the conditions of a case for which he is about to accept responsibility permit him to provide his own highest quality of medical care."

(2) "The physicians of the United States of America pledge themselves to continue their search and activity, in whatever social environment may develop, to secure or to restore the freedom, high quality, and availability of medical care which has been traditional in our country."

(3) Reaffirm Section 6 of the "Principles of Ethics" of the AMA which states: "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."

(4) Reaffirm the principles of the **Bauer Amendment** adopted in 1961 which states: "The House of Delegates of the AMA believes the medical profession will see to it that every person receives the best possible medical care regardless of ability to pay, and it further believes that the medical profession will render that care according to the system it believes is in the public interest, and that it will not be a willing party to implementing any system which it believes to be detrimental to the public welfare."

(5) The House of Delegates "restates its offer to meet with the President of the United States through our legislative Task Force to discuss proposed medical care legislation with a view to safeguarding the continued provision of the highest quality and availability of medical care to the people of the United States."

(6) The House of Delegates of the AMA "instruct the Board of Trustees of the AMA to embark immediately on an active campaign to inform the membership of the AMA of the grave considerations in adhering to our Principles of Ethics, posed by legislation now pending before Congress."

(7) That the AMA "strongly urge those branches of the government interested in the

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formulation, the enactment, and the implementation of laws which deal with provision of professional medical services to the public to seek and utilize the advice and assistance of the physicians who will render such service. Such advice and assistance should be received through our chosen representatives, the officers of the American Medical Association.

(8) "When the fate of the pending medicare legislation is determined, this House will review, in special session if necessary, the effect of the law and take whatever action is deemed necessary."

In following these directions from the House of Delegates, the President of the AMA and the Task Force of the Board of Trustees met with President Johnson and officials of the Department of Health, Education, and Welfare, on July 29, 1965. The AMA issued the following statement after the conference:

"We will watch developments in this new program and offer constructive suggestions, both to Congress and to the Administrators of the program, in the interest of the maintenance of the highest quality of medical care.

"President Johnson has requested that we meet with officials of the Department of Health, Education, and Welfare on the development of rules and regulations.

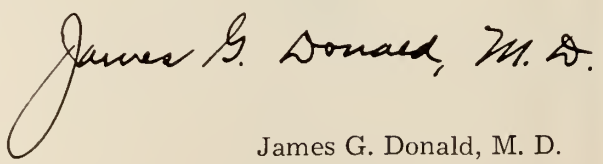
"Following our conference with Mr. Johnson on Thursday, initial meetings were held with HEW Secretary Celebrezze (recently replaced as HEW Secretary by John W. Gardner), exploring arrangements for AMA and HEW review of projected regulations and the problems of administration and interpretation of the law.

"The President also asked that we report back to him in two months on our progress."

Mr. Wilbur Cohen assured the group that no regulations would be promulgated until AMA had an opportunity for study and to make suggestions.

It remains to be seen whether the voice of the AMA will be heeded in establishing the rules and regulations under this new law. If it is not heeded, the response of the entire profession may need to be united in recommending the ethical desirability of nonparticipation as individual physicians. If it is heeded, the lines of communication between organized medicine and the Department of Health, Education, and Welfare should be kept open to contain, modify, control, or reject objectionable aspects of this and other health legislation which would pose valid ethical problems for practicing physicians.

Meanwhile, it is certainly ethical, moral, and legal for individual physicians to decide for themselves whether or not the conditions of a case or the applicable rules and regulations seriously interfere with the quality of care that the physician can render. If they do interfere, the individual physician is ethically obligated not to participate. If they do not interfere, the individual physician is ethically obligated to participate. This is not a matter for Medical Society or Medical Association action until further guidance is obtained from the House of Delegates of the AMA. Based on its evaluation of and participation in the formulation of the rules and regulations for implementation of the law, this House of Delegates will furnish members of the medical profession guidelines for future action. Certainly we must not relax our opposition to socialized medicine and must fight any further effort in this direction at the local ballot box, in the courts, and in Washington. If doctors all over the country see to it that we elect Congressmen and Senators who represent our point of view, the battle will be won. Significant financial support of your ALAPAC request will be an important step in this direction.



James G. Donald, M. D.



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IN BRIEF:

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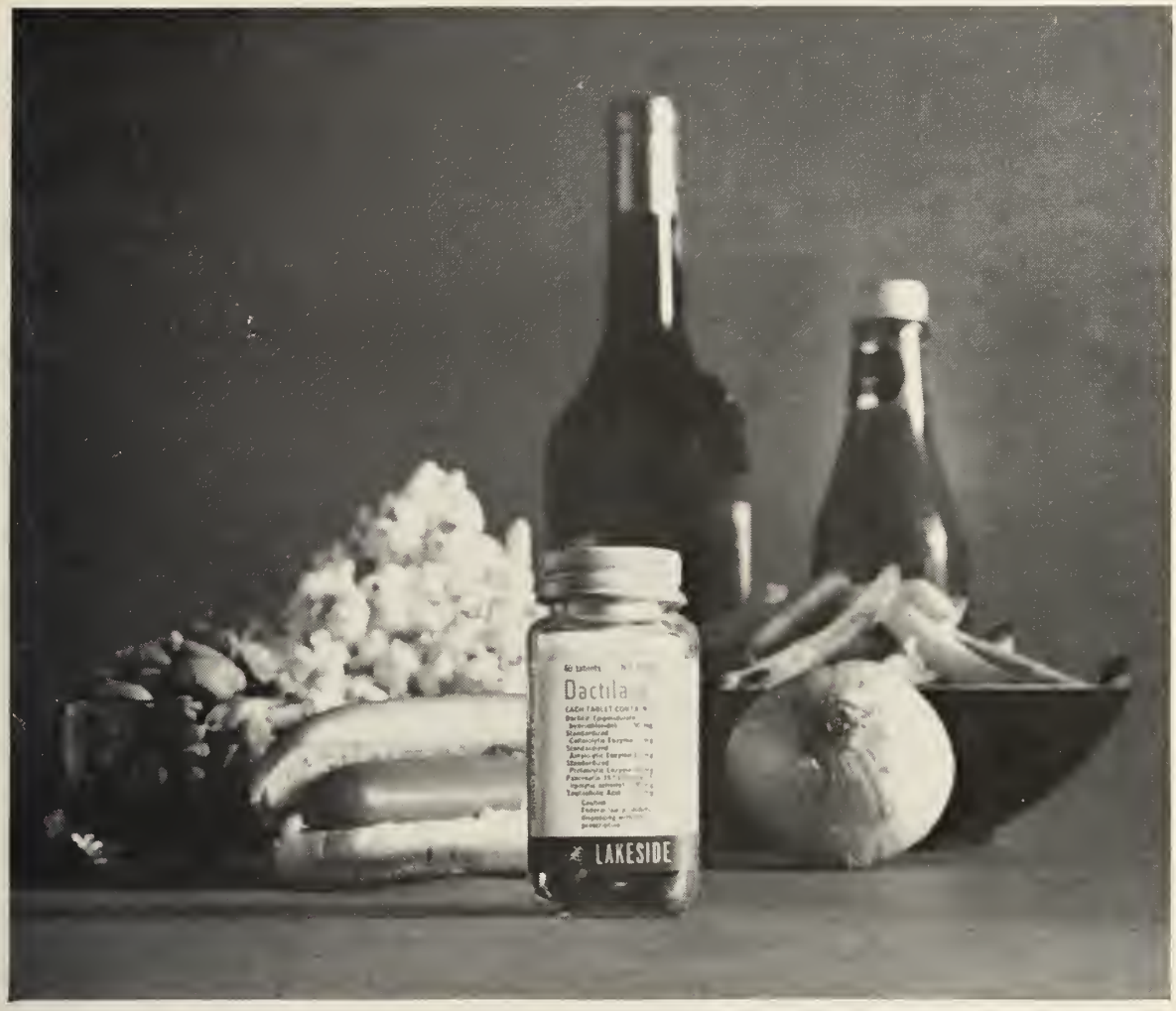
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ALABAMA DOCTORS GO TO THE MOUNTAIN

Physicians of Alabama have taken a leaf from Mahomet's notebook: When the Legislature failed to meet the financial needs of the State Department of Public Health, members of the Medical Association of the State of Alabama went to the Legislature.

Armed with startling data supplied by Dr. Ira L. Myers, State Health Officer, revealing the acute financial distress of his department, physicians launched a state-wide campaign to correct the deficiencies.

The battle began in the grass roots with speeches and other public presentations by Dr. Myers and members of county medical societies. Officers of this Association, as well as members of the Board of Censors, worked tirelessly to impress the message on the people.

Newspapers quickly took up the call with the result that legislators came to Montgomery for their biennial session with a virtual mandate to rescue the Health Department from its deplorable state.

The success of that campaign is now history but its results will benefit the citizens of this state for many years to come. With additional funds from a one-cent-per-package tax on cigarettes, the Health Department now has enough money to meet competition for such trained professional personnel as physicians, nurses, sanitarians, dentists, laboratory technicians, etc.

Two new laws were necessary to accomplish this: The first would bring a minimum of two million dollars annually from the cigarette tax; and the second would remove unreasonable salary limitations on Health Department salaries for professionals.

It was a long, hard fight but the battle eventually was won. The way now is paved for the Department of Health to achieve its glory of yesteryear when it was rated the most advanced in the United States.

In heralding the victory, proper credit should be accorded to those hundreds of officers and members of county medical societies who rose magnificently to the challenge. It was they who carried the fight right to the doorsteps of every registered voter in their county.

More than one physician took time from a burdened schedule to explain the urgency to a civic club, or to make radio and TV appearances. Newspapers throughout Alabama turned to hometown physicians to keep them informed of the progress of the fight. Through news and editorial page columns, both citizenry and legislators learned that nothing short of all-out support would adequately protect the millions of Alabamians who look to the Department of Public Health for a program of preventive medicine.

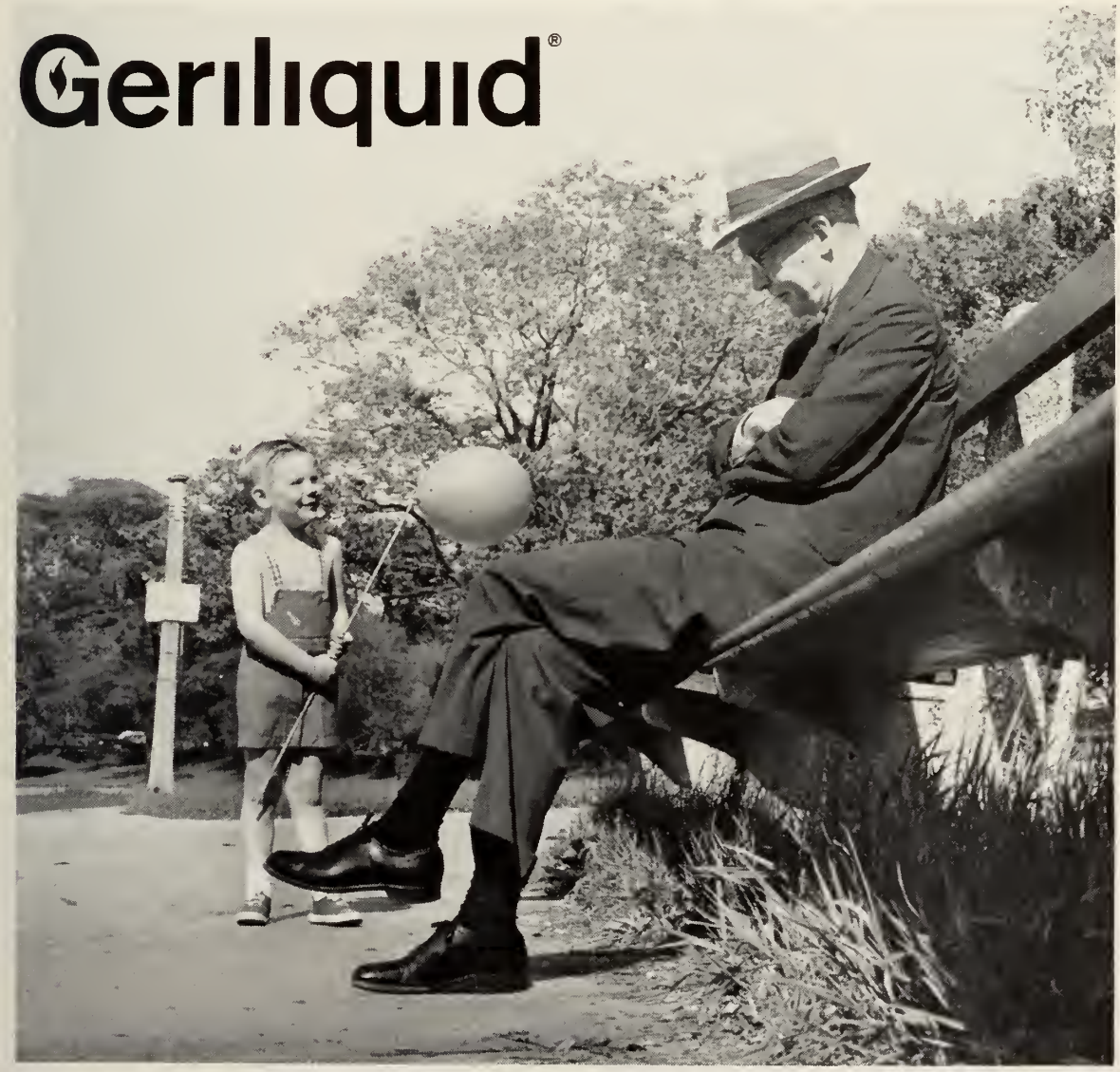
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Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.

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ture without whose support we could not have won the fight.

House Speaker Albert Brewer and Representatives Rankin Fite, John Hawkins, Sim Thomas and Alton Turner rendered invaluable assistance. On the Senate side it is more difficult to extend individual credit, for every Senator with very few exceptions answered the call of medicine without personal stint. Outstanding, perhaps, is Sen. A. C. Shelton who personally rammed the salary bill through that body. Other senators who rendered yeoman service on the tax-for-health measure included Sen. James Clark and Sen. Roland Cooper.

(Note: That doctors in the grass roots served well is reflected in the paragraph above. It is significant that all three senators mentioned constituted a powerful bloc which repeatedly clashed with MASA's aims just two years ago.)

Now that a battle has been won to attain financial support for the Department of Health, there remains the war ahead which must be fought on two fronts: First, the Department must locate and employ the many professional workers necessary to fill its ranks, and; second, the Department must now move resolutely from horse-and-buggy to Nuclear Age medicine.

Sensational advancements in preventive medicine techniques are awaiting officials and employees of the Alabama Department of Public Health. Until this time, it has been impossible to take advantage of them because of a serious shortage of funds.

No longer is this true. The Department will receive at least two million dollars additional during the next two years and the figure could go as high as three million dollars per year. Dr. Myers has stated that this sum is the maximum that he can use at this moment but that a few years hence even more funds will be needed.

When that time comes, a politically-experienced Medical Association of the State of Alabama should say in loud, clear voices: "Let the battle commence."

SOME PROBLEMS REQUIRE MORE CAUTION

A thorny problem arising from passage of the Medicare law concerns physician participation in the program.

Doctors of Alabama have only to look toward Europe and its socialized medicine societies to determine the dangers inherent in Medicare. The practice of medicine is too advanced in this country, the technological developments have shed blessings on too many people to be threatened now by sociologists and bleeding heart do-gooders.

But from the highest councils of medicine come words of caution against any abrupt actions which could reflect disadvantageously against medicine and its practitioners.

Just as the proponents of Medicare patiently bided their time for two decades for the propitious moment, so may it be necessary for medicine to move with deliberate caution in applying the brakes and reversing the dangerous trend of socialized medicine.

The President of the Medical Association of the State of Alabama, Dr. James G. Donald, has explored this entire subject in scholarly fashion in his monthly article appearing on page 146 of this issue of the *Journal.* It is recommended as prime reading for those stalwarts who would plunge headlong into a fray until all the ammunition has been inventoried.





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prescribe improved belladonna therapy with more potent and





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ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

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Not all patients are so lucky as to have retired to Florida, where they can pick citrus fruit off their own trees. But any patient anywhere can get the same benefits of the natural vitamin C in Florida oranges, grapefruit, and tangerines . . . thanks to modern methods of processing fresh fruit. Whether it is frozen, canned, or in cartons, 98% of the vitamin C content of the fruit is preserved.

Grapefruit and other citrus fruits filled with vitamin C are valuable in the nutrition of every age group. Among the teen-agers, vitamin C is one of the two nutrients most often low in the diet. Infants, too, need generous amounts of vitamin C; and they will take it readily when it comes to them in the form of delicious orange juice.

When your patient chooses *Florida* citrus, he can be sure of getting fruit filled with natural goodness and of just the right sweetness. Florida citrus is unexcelled because a State commission watches over the entire Florida citrus crop to see that it meets the world's highest standards for fresh, frozen, canned, or cartoned citrus fruit.

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approximating the diuretic efficacy of meralluride

METAHYDRIN®

(trichlormethiazide)

To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin® (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

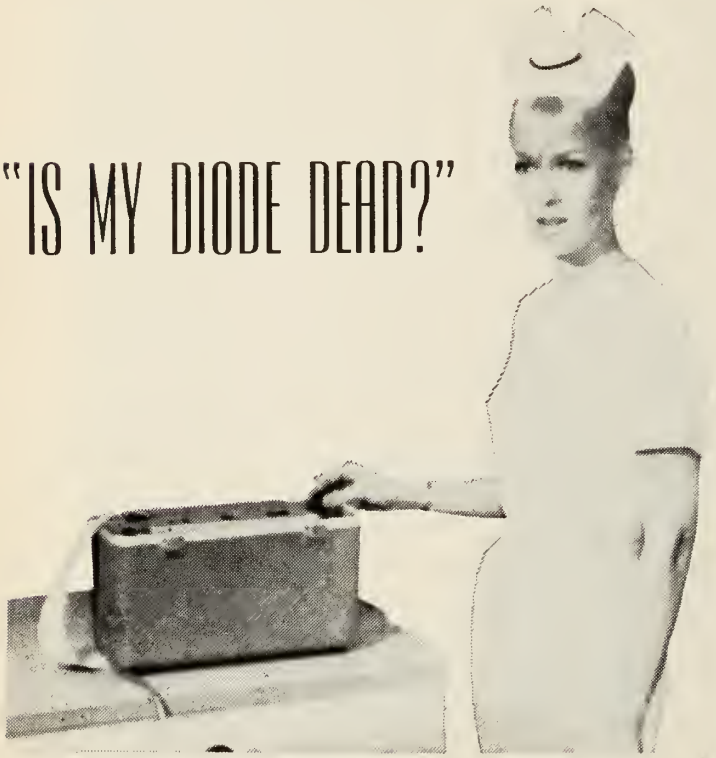
PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

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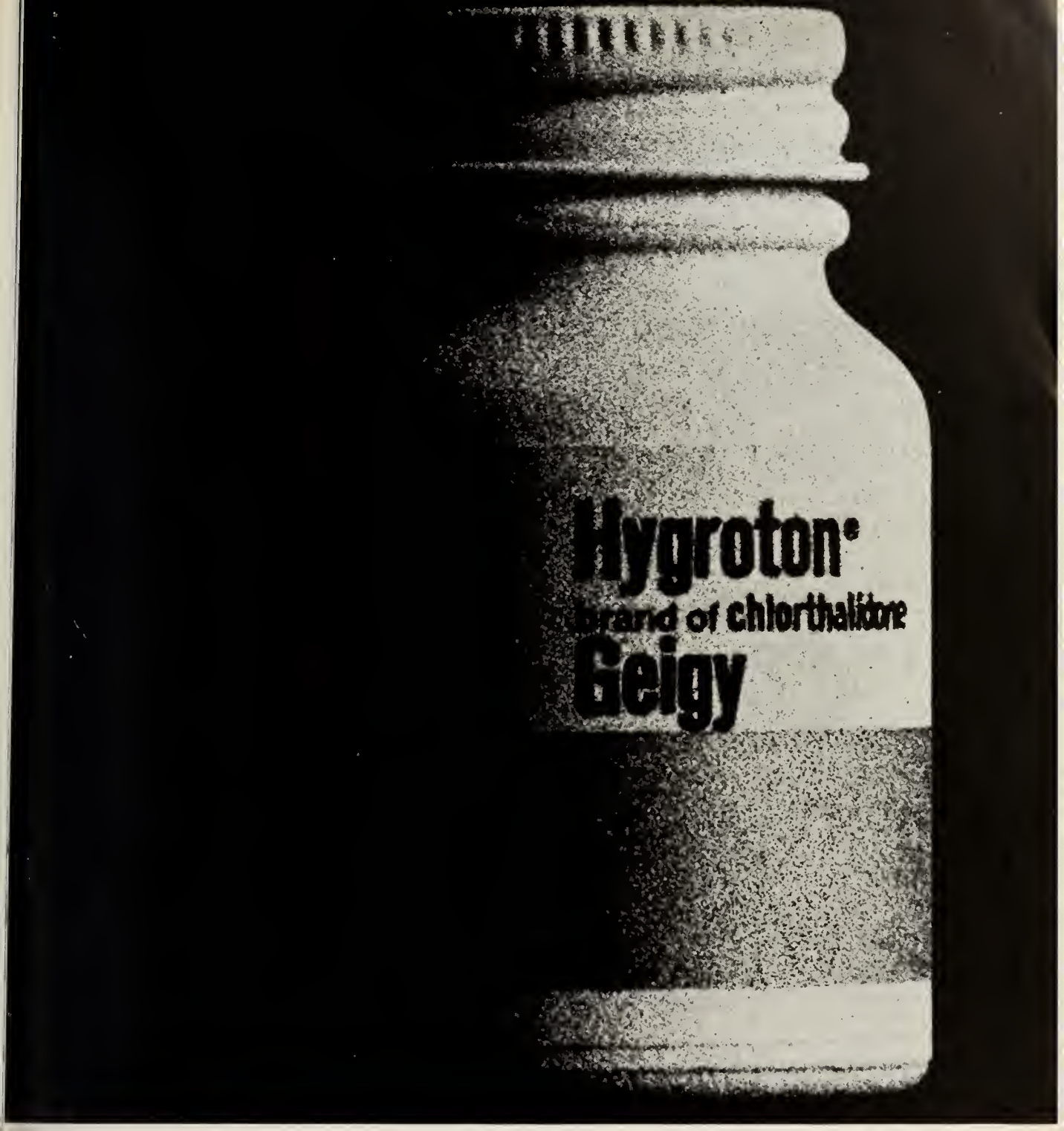
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Indications: Many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

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The long-acting diuretic



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Patients with edema.
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Patients you want to bring to dry weight.
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Those resistant to other therapy.
And those intolerant of other diuretics.
Those who have to pinch pennies.
And those who can afford the best.

CLINICAL CONVENTION FOR MAN IN PRACTICE

By James Z. Appel, M. D.

President, American Medical Association

The American physician is well aware that he must keep abreast of new findings in therapy and research to be able to provide the best possible care for his patients.

He must know about new drugs and their uses and possible side effects. He must know about new techniques of surgery. He must know of the promising leads toward solution of now baffling physical ills. And he must know of the sometimes small but often important new successes in finding better ways to treat the already treatable diseases.

There's no argument about the premise that the physician must keep learning. The problem is how. With the average American physician now working a 58-hour week, and many putting in hours far above the average, how can the physician find the time to study and keep abreast?

One of the most compact methods of checking up on new developments is to attend the annual clinical convention of the American Medical Association. The program of this convention is designed primarily for the man in practice. The speakers will read papers that bring to the man in practice the latest findings of others in his area.

This year the clinical convention will be held in my home state of Pennsylvania, Nov. 28-Dec. 1, in Philadelphia.

The Philadelphia meeting offers an excellent scientific program. Topics of wide interest will be discussed by outstanding teachers. All of the various sessions and workshops will contribute to the continuing education of the practicing physician.

Particularly noteworthy are the postgraduate courses in gynecology and obstetrics and in cardiovascular therapeutics, consisting of two series of comprehensive lectures.

Other sessions will be devoted to timely subjects, followed by question-and-answer or discussion periods. Fireside conferences and breakfast roundtables will provide further time for informal discussion.

It promises to be a stimulating four days, worthy of the busy physician's time. I urge every physician to take advantage of the educational opportunity represented by the clinical convention.

PETER-PAUL

The White House economic wizards have discovered with some alarm that the impending tax cuts are going to be neutralized by increases in Social Security, notably to foot the bill for Medicare.

It's the old story of taking out of one pocket and putting in another; at times it can be perfectly good business. But the question here is, what happens to the business the tax cut was supposed to stimulate?

Reprint from the Montgomery Advertiser, Tuesday Morning, August 24, 1965.

the price of "success"

190/102

Hypertension has been called the price of success... and in some life-situations, the cost of failure. In either event, Metatensin lowers blood pressure, cushions the patient against stress and retards the progress of disease. Metatensin is effective and economical. It is well-tolerated over long periods.

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YOU CAN STAY
WITH

METATENSIN®

EACH SCORED TABLET CONTAINS:
Metahydrin® (trichlormethiazide) 2 mg. or 4 mg. Reserpine 0.1 mg.

In Brief: Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery. Contraindications are complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.
Supplied: Metatensin tablets, 2 mg., 4 mg. — bottles of 100 and 1000.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

COMPLIANCE STATEMENTS

"Statements of Compliance" with the federal Civil Rights Act were sent to physicians by state agencies in several states recently. The physicians were asked to sign these forms and return them to the state office sending them out.

Some physicians who received the "Statements of Compliance" felt their signatures were being requested on an unnecessary pledge. They asked the American Medical Association's Office of the Counsel General to comment concerning the legal considerations involved.

Title VI of the Civil Rights Act requires that there shall be no discrimination on the basis of race, color or national origin under any program receiving federal financial assistance, explained the AMA counsel.

Any agency which desires to continue to receive such federal financial assistance must give the federal agency providing that assistance written assurance of compliance with the Civil Rights Act. The assurance must cover the performance of the services of individual physicians where the program includes this.

A statement of this nature need not be interpreted as containing an implication that the doctors who sign it have in the past practiced racial discrimination or are likely to do so in the future, said an AMA attorney.

No physician is required to contract for performance of services for patients who are beneficiaries of a federally assisted program, the attorney pointed out. However, those who do so have to satisfy the state agency that they will not on the basis of race, color, or national origin, discriminate or segregate in the treatment of such welfare patients.

Title VI of the Civil Rights Act applies only to services performed under such contracts, explained the attorney. It does not extend to the services rendered to private patients who are not beneficiaries of a federally assisted program.

A statement of compliance acceptable to the federal government would have to specify clearly the kinds of prohibited conduct to be avoided, but the federal government does not prescribe the exact language to be used.

Use of some form of statement of compliance is probably the easiest way for a state agency to meet its obligations under the Civil Rights Act, the attorney said. It was unfortunate, he added, that state agencies had not conferred with state medical societies before sending out the statements of compliance. This approach could have avoided misunderstandings.

FOUNDATION SURVEYS NATIONWIDE FACILITIES FOR DIAGNOSIS, TREATMENT OF EPILEPSY

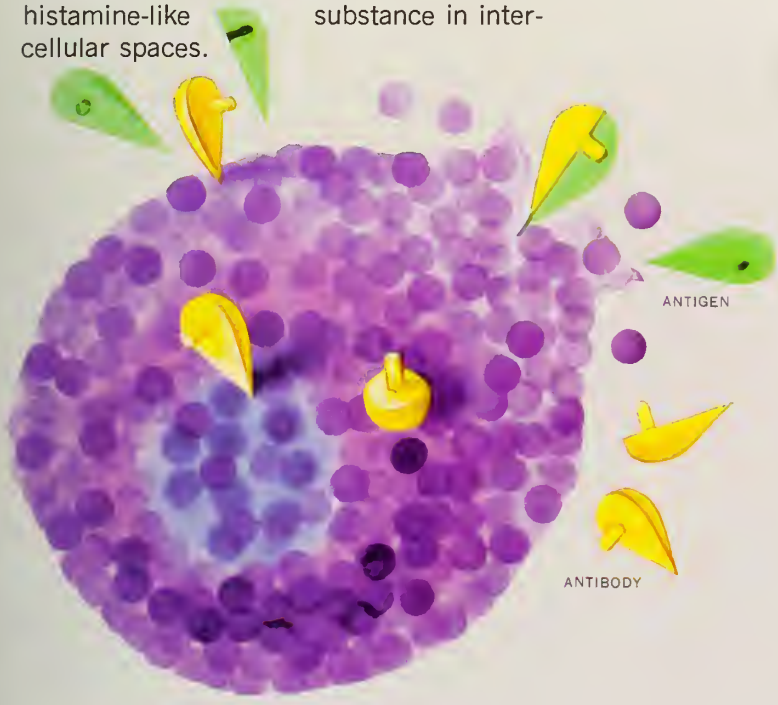
Washington, August 11—The Epilepsy Foundation has this week issued a national survey of 225 clinics and other facilities available for the diagnosis and treatment of epilepsy. A Foundation spokesman said that this was the first such compilation ever made.

The 56-page booklet contains detailed information about each clinic—including, what services the facility provides (for example, child guidance, psychiatric, or diagnostic), and the number and specialties of physicians on the staff.

The publication is available free to professionals. Individuals needing information about treatment and diagnostic facilities may write to the Foundation for single copies of the page relating to the state where they reside.

in theory, allergy begins like this:

When antigens invade the body, antibodies, formed chiefly by plasma cells, may become attached to mast cells. If the same antigen reappears and reacts with the antibodies, the mast cell disrupts (as pictured below). Subsequently, the "exploding" mast cell deposits granules of bound histamine or histamine-like substance in intercellular spaces.



in allergy, Dimetane® Extentabs®

(brompheniramine maleate, 8 mg. & 12 mg.)

work with no more sedation than placebo*

Although the mechanisms of allergy are still theoretical, the response to Dimetane (brompheniramine maleate) is ample proof that a good antihistamine can, and does, work—and (as reported in one investigation*) with no more sedation than placebo. Dimetane (brompheniramine maleate) assures your allergy patients prompt relief of symptoms while usually permitting them to lead active, alert lives. And a single Extentab provides continuous action for up to 10-12 hours.

*Schiller, I.W. and Lowell, F.C.: New England J. Med. *261*:478, 1959.

BRIEF SUMMARY: *Contraindications:* Hypersensitivity to antihistamines. Not recommended for use during pregnancy. *Precautions:* Until response is determined, patient should be cautioned against engaging in mechanical operations requiring alertness. *Side Effects:* Hypersensitivity reactions, including skin rashes, urticaria, hypotension, and thrombocytopenia have been reported rarely. Occasional transitory drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. *Other dosage forms available:* conventional tablets (4 mg.); Elixir (2 mg./5 cc.); Injectable (10 mg./cc. ampuls, and 100 mg./cc. in 2 cc. vials).

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PHARMACEUTICALS | RESEARCH

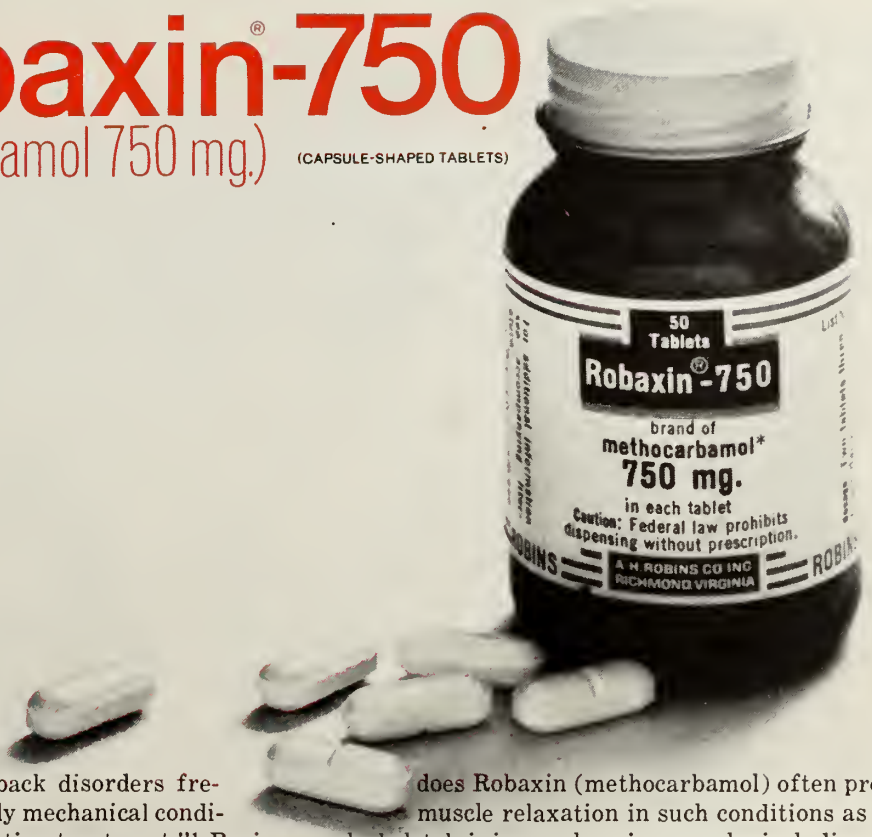
basic therapy in low-back pain: bed, board, heat

Whether low-back pain is in the chronic or acute phase, the appropriateness of bed rest for such a patient is beyond controversy. Boards placed under the mattress, for a firmer bed to further immobilize the spine, are another common recommendation. And most investigators consider heat beneficial—moist heat in particular.[1-5]



and Robaxin®-750

(methocarbamol 750 mg.) (CAPSULE-SHAPED TABLETS)



It has been noted that low-back disorders frequently "... are caused by truly mechanical conditions which yield to conservative treatment."[1] Basic to this conservative treatment are bed rest, a board for the bed, and applied heat. In addition, a good muscle relaxant is often helpful, as "... muscle relaxants are useful in chronic as well as acute low backaches."[4]

Robaxin (methocarbamol) has relieved spasm and pain in cases where the patient "had not responded to conservative measures prior to drug therapy."[6] A 100-patient study showed that Robaxin provided greater relief of muscle spasm for a longer period of time without adverse reactions "than any other commonly used relaxants...."[6]

A well-tolerated[7] skeletal muscle relaxant with "specificity of action,"[7] methocarbamol leaves normal muscle tone unaffected. Moreover, there is little likelihood of sedation[7]—a considerable advantage for the patient who must remain active and alert on his job.

Significantly, clinicians advise using a muscle relaxant "early and in adequate dosage."[8] In this regard, Robaxin (methocarbamol)—*particularly in the 750 mg. dosage (2 tabs. q.i.d.)*—offers optimal therapeutic benefits without a significantly increased incidence of side effects. And just as it works well as part of the basic regimen for low-back pain, so also does Robaxin (methocarbamol) often provide muscle relaxation in such conditions as musculoskeletal injury, chronic neurological disorders, and orthopedic situations.

BRIEF SUMMARY—Robaxin (methocarbamol) Tablets: Contraindicated in hypersensitive patients. Side effects (light-headedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently.

ALSO AVAILABLE: Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)
Robaxisal® (methocarbamol with aspirin) and Robaxisal-PH Tablets (methocarbamol with Phenaphen®).

REFERENCES: 1. Soto-Hall, R.: Med. Sci. *14*:23, 1963. 2. McCarrol, H.R.: Paper read at the Annual Meeting of the American Medical Association, Atlantic City, June 16-20, 1963. See Medical News: J.A.M.A. *185*:39 (July 13), 1963. 3. Gordon, E.J.: Med. World News *5*:54, 1964. 4. Cozen, L.: GP *26*:82, 1962. 5. Larson, C.B.: Postgrad. Med. *26*:142, 1959. 6. Forsyth, H.F.: J.A.M.A. *167*:163, 1958. 7. Weiss, M., and Weiss, S.: J. Amer. Osteopath. Ass. *62*:142, 1962. 8. Rowe, M.L.: J. Occup. Med. *2*:219, 1960.

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AUDIO-DIGEST ISSUES NEW LIBRARY OF TAPE RECORDINGS

A library of more than 300 one-hour tape recordings, devoted to comprehensive discussions of everyday office problems by leading specialists, has just been released to the medical profession by the Audio-Digest Foundation, Los Angeles.

According to the Foundation's Medical Board, the 1965 "Catalog of Classics" makes available to individual physicians, hospitals, and clinics, ideal Journal Club and teaching material in seven specialty areas: Anesthesiology, Obstetrics-Gynecology, Surgery, Pediatrics, Internal Medicine, Ophthalmology, and General Practice. A number of tapes also focus on the Basic Sciences, Cancer, Psychiatry, Gastroenterology, Cardiology, Arthritis, Geriatrics, and Hematology.

Many of the recordings represent carefully-edited, on-the-spot reports from several hundred major meetings of such groups as the American Medical Association, American College of Physicians, American Society of Anesthesiologists, American College of Obstetricians and Gynecologists, as well as condensations of major university postgraduate courses.

According to the Medical Board, the selected recordings represent the latest and most authoritative reviews of modern-day diagnosis and treatment, in the actual voices of America's finest teachers and clinicians. This special library of titles represents the best of programs produced in the regular subscription programs of the Audio-Digest Foundation (a nonprofit subsidiary of the California Medical Association) during the past 11 years.

The Catalog of Classics is available free of charge and may be obtained by writing the Foundation Editorial Offices at 619 S. Westlake Avenue, Los Angeles 90057.

August 10, 1965

The Medical Association of the
State of Alabama
19 South Jackson Street
Montgomery 4, Alabama

On behalf of the Alabama Medical Assistants Association I would like to express my sincere thanks to you, the University of Alabama, and all those who worked to make the 4th Annual Seminar a tremendous success.

We have seen this effort grow since its inception four years ago and we feel that this growth is mainly due to the sincere cooperation and active participation of our doctors. This year we were privileged to have in attendance not only members of our Association but also many interested physicians. The Seminar also attracted visitors from other states.

Thank you again for helping us to help you by supporting our efforts to become more knowledgeable in the subjects relating to the work of medical assistants.

Sincerely,
Martha Foote
(Mrs.) Martha Foote, Chairman
4th Annual Alabama Medical
Assistants Seminar



THE NEW PHYSICIAN • *January 1965*
Reprinted from *"The New Physician"*



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An efficacy rate of 99% has been demonstrated with Schwarz Strain live measles vaccine (Lirugen). In recent clinical trials, Lirugen was administered without gamma globulin to approximately 13,000 children. In 1,405 of these children tested serologically, a conversion rate of 99% was reported. Close medical follow-up of inoculated children and controls showed no significant differences between mean maximum temperatures in the two groups. The incidence of high fever (103°F and above, rectally) attributable to the vaccine could be calculated at less than 1%, and the occurrence of mild, transient rash at less than 3%.

Lirugen is the most highly attenuated, but fully antigenic, live measles vaccine. Additional special passages of the original Edmonston Strain by Schwarz resulted in further attenuation which reduces systemic reactions so effectively that the use of gamma globulin with Lirugen is not needed.

Contraindications: Pregnancy; leukemia, lymphoma and other generalized malignancies; brain damage in children under one year of age; febrile illness; allergy to egg proteins, neomycin, or streptomycin. Precautions: Use cautiously in patients with a history of tuberculosis and patients being treated with steroids, irradiation, alkylating agents, and antimetabolites. Consult package literature before administering Lirugen.

References:

1. Schwarz, A.J.F.: Amer. J. Dis. Child., **103:** 386-389, 1962.
2. Krugman, S. et al.: Pediatrics, **31:** 919-928, 1962.
3. Andelman, S. L. et al.: J.A.M.A., **184:** 721-723, 1963.
4. Measles Vaccines: W.H.O. Technical Report Series No. 263, 1963.
5. Schwarz, A.J.F.: Annales Paediatrici, **202:** 241-253, 1964
6. Morley, D. C. et al.: Bull. W.H.O., **30:** 733-739, 1964.
7. Krugman, S. et al.: J. Pediatrics, **66:** 471-488, 1965.
8. Andelman, S. L. et al.: Scientific exhibit at annual meeting of The American Academy of Pediatrics, 1964.

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Pipradrol hydrochloride		2 mg.
Vitamin B_1 (thiamine hydrochloride)	(10 MDR*)	10 mg.
Vitamin B_2 (riboflavin)	(4 MDR*)	5 mg.
Vitamin B_6 (pyridoxine hydrochloride)		1 mg.
Nicotinamide	(5 MDR*)	50 mg.
Choline†		100 mg.
Inositol†		100 mg.
Calcium glycerophosphate	(2% MDR for calcium and phosphorus)	100 mg.
Cobalt (as chloride)		1 mg.
Manganese (as sulfate)		1 mg.
Magnesium (as acetate)		1 mg.
Zinc (as acetate)		1 mg.
Molybdenum (as ammonium molybdate)		1 mg.
Alcohol 15%		

*Multiple of adult Minimum Daily Requirement supplied
†Requirement in human nutrition not yet established

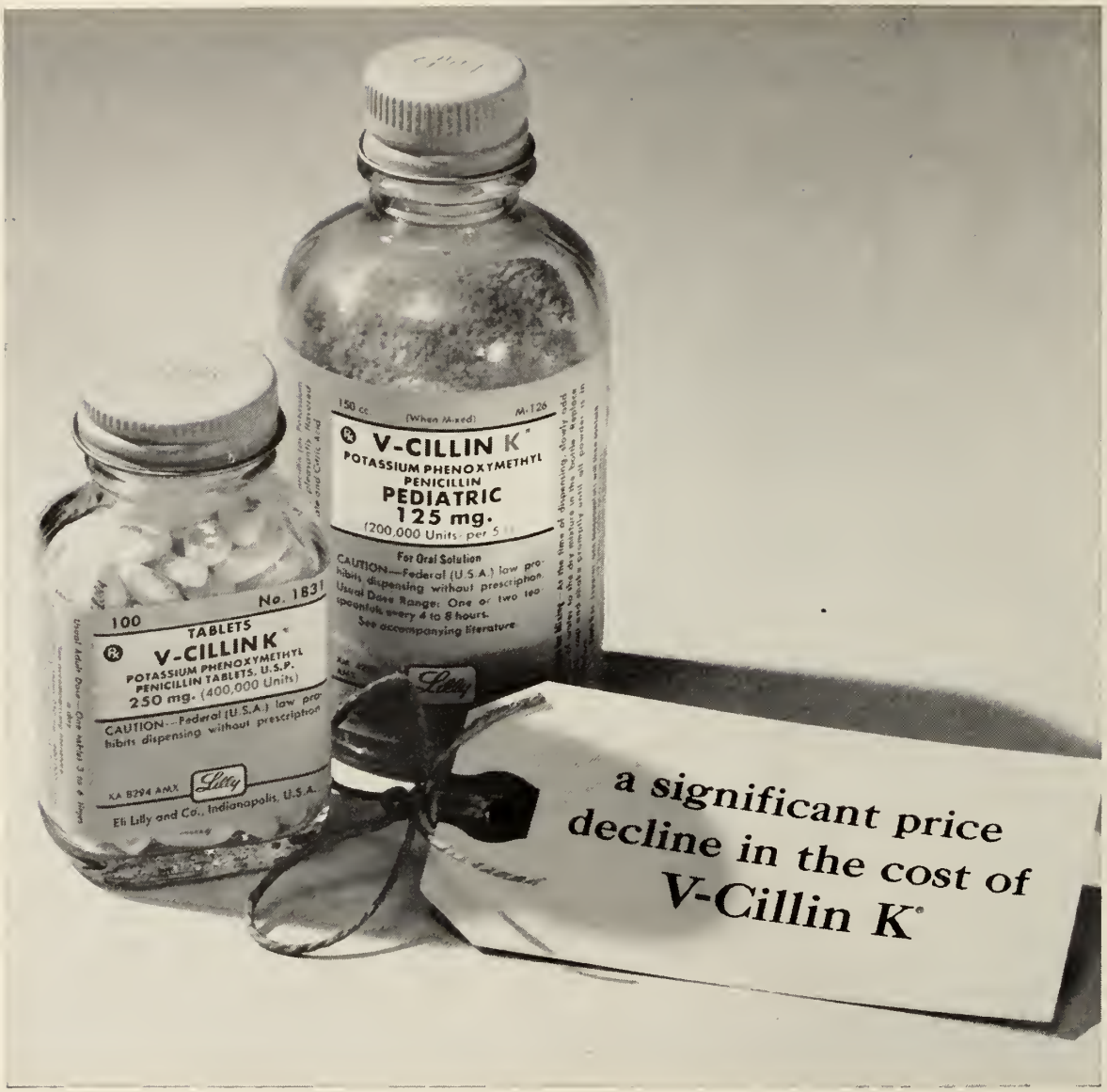
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Anyone can feel tired and "old" too soon. In such functional fatigue, Alertonic helps to lift mood, revive interest, restore purposeful activity promptly. Yet it contains no MAO inhibitors, no hormones. Alertonic is the effective formulation of a cerebral stimulant (pipradrol hydrochloride), alcohol, vitamins, and minerals ... available on prescription *only*. For common functional complaints (mild mood depression, tiredness); geriatric or convalescent patients, Rx one *tablespoonful* Alertonic *t.i.d.*, thirty minutes before meals. Contraindicated in agitated pre-psychotic patients, paranoia, or other patients in whom hyperexcitability, anxiety, chorea, or obsessive-compulsive states are present. Mild central stimulant side effects may occasionally occur.

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The effectiveness of intramuscular penicillin. Just three 250-mg. doses daily provide total twenty-four-hour penicillin blood levels equal to those achieved by injection of 600,000 units of procaine penicillin G. A fourth dose increases daily penicillemia to levels 35 percent above those achieved by injection.

Consistent dependability—even in the presence of food. Comparative pharmacologic data show that V-Cillin K produces peak blood levels *twice* as high as those of penicillin G, with *half* the dose.

New, thin coating . . . new size and shape. The new coating eliminates the characteristically bitter taste of oral penicillin and makes V-Cillin K tablets easy to swallow. The new shape makes them easy for physicians and pharmacists to identify.

Indications: V-Cillin K is an antibiotic useful in the treatment of streptococcus, pneumococcus, and gonococcus infections and infections caused by sensitive strains of staphylococci.

Contraindications and Precautions: Although sensitivity reactions are much less common after oral than after parenteral administration, V-Cillin K should not be administered to patients with a history of allergy to penicillin. As with any antibiotic, observation for overgrowth of nonsusceptible organisms during treatment is important.

Usual Dosage Range: 125 mg. (200,000 units) three times a day to 250 mg. every four hours.

Supplied: Tablets V-Cillin K, 125 or 250 mg., and V-Cillin K, Pediatric, 125 mg. per 5-cc. teaspoonful, in 40, 80, and 150-cc.-size packages.

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THE JOURNAL
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THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA
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Homeostasis: A Study In Carbohydrate Metabolism

by

E. Cheraskin, M. D., D. M. D.

and

W. M. Ringsdorf, Jr., D. M. D., M. S.

Department of Oral Medicine
University Medical Center
Birmingham, Alabama

Introduction

In the final analysis, life or death is a function of homeostasis. The cells singly and collectively as a total organism survive when host resistance can cope successfully with the many and diverse environmental threats. When the homeostatic machinery collapses, host susceptibility replaces host resistance. The same environmental challenges now overwhelm the system and disease and then death ensue.

While much about homeostasis is still unknown, it is clear that metabolism echoes the homeostatic state. One such measure is carbohydrate metabolism.

An attempt will be made in this report to answer the following five questions:

1. What is the carbohydrate metabolic picture of a presumably healthy person during a routine day?

2. How does carbohydrate metabolism relate to the sugar equivalent of carbohydrate foods in a regular diet?

3. What changes in carbohydrate metabolism follow a decrease in refined-carbohydrate (sugar and white flour) ingestion?

4. Is there any relationship between carbohydrate metabolism and the physiologic state (e. g. blood pressure)?

5. Can physiologic state (e. g. blood pressure) be significantly altered by reducing refined-carbohydrate intake?

Method of Investigation

Seven dentists participated in this program during a two-week period. On the Monday through Thursday of the first week, the seven subjects carried out their usual activities

while consuming their regular diets. On Thursday each participant reported to the Oral Medicine Clinic at 8:00 A. M. fasting (immediately before an 8:15 A. M. breakfast), 10:00 A. M. (about 30 minutes after the usual 9:30 A. M. coffee-shop visit), 12:00 noon (about 30 minutes prior to the 12:30 P. M. lunch), 2:00 P. M. (about one hour before the customary 3:00 P. M. coffee break) and at 4:00 P. M. At each visit the blood glucose (Somogyi-Nelson method) was determined. Also, at each of the sessions, blood pressure was recorded.

The following Monday through Thursday the subjects carried out their usual duties. However, as far as possible, refined-carbohydrates (sugar and white flour products) were eliminated from the diet. On Thursday, the subjects reported to the clinic for blood glucose and blood pressure measurements as earlier reported for the initial visit.

Results

Question One: Table 1 lists the blood glucose values for the seven subjects at the five different time intervals during the initial visit. The overall individual spread is 115 mg. per cent. It is of parenthetic interest that there are significant differences of the means and the variances between all temporal points except the 10:00 A. M. and noon values. Figure 1 pictorially portrays the mean blood glucose fluctuations in the seven subjects during the experimental day (interrupted lines). The spread for the entire group is approximately 46 mg. per cent (73.4 to 119.0 mg. per cent).

Within the limits of these observations and of the reported literature,[1-4] carbohydrate metabolism (as measured by blood glucose) fluctuates significantly during the day and the oscillations differ among the various participants.

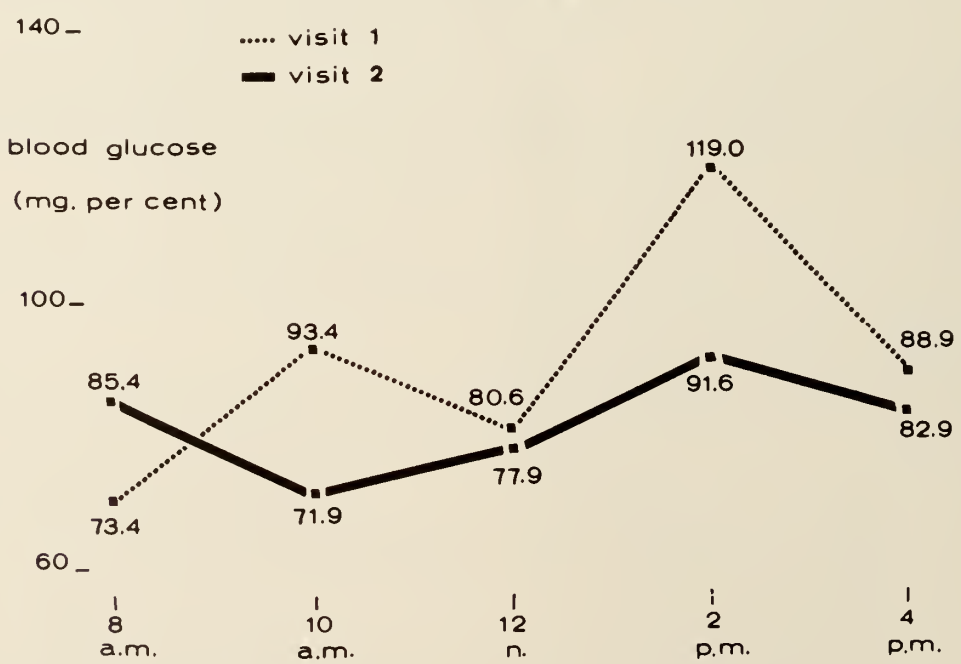


Figure 1. Daily fluctuations in mean blood glucose following a three-day regular diet (visit 1, interrupted line) and after a three-day decrease in refined-carbohydrate foods (visit 2, continuous line).

Table 1

blood glucose values in seven dentists following a three-day regular diet

subjects	8:00 A. M.	10:00 A. M.	12:00 N.	2:00 P. M.	4:00 P. M.
RiBl	70	117	60	140	83
BrSp	70	83	72	105	92
ShDu	63	77	72	110	110
YoKa	71	92	83	80	77
ThSh	77	102	87	175	85
WiGr	85	100	90	111	85
HeBr	78	83	100	112	90
mean	73.4	93.4	80.6	119.0	88.9
S. D.	7.1	13.9	13.4	30.2	10.5
range	63-85	77-117	60-100	80-175	77-110
significance of the difference of the means		<0.050	>0.100	<0.025	<0.050
significance of the difference of the variances		$=0.025$	$=0.500$	$=0.005$	$=0.0005$

Table 2

daily dietary sugar equivalent (expressed in teaspoonsful) during a three-day regular diet regime

subjects	8:15 A. M.	9:30 A. M.	12:30 P. M.	3:00 P. M.	6:00 P. M.
RiBl	7.9	5.5	23.4	4.5	24.3
BrSp	17.1	1.5	12.2	2.0	26.4
ShDu	22.3	0.0	16.1	7.5	28.9
YoKa	6.5	0.0	10.6	0.0	17.9
ThSh	6.9	8.5	25.0	1.8	20.5
WiGr	9.4	2.5	11.5	2.7	12.1
HeBr	12.0	5.0	15.9	2.2	17.8
mean	11.7	3.3	16.4	3.0	21.1
S. D.	5.9	3.2	5.8	2.4	5.8
range	6.5-22.3	0.0-8.5	10.6-25.0	0.0-7.5	12.1-28.9
significance of the difference of the means		$=0.500$	<0.001	<0.001	<0.001
significance of the difference of the variances		$=0.100$	$=0.100$	$=0.025$	$=0.025$

Question Two: There are undoubtedly many factors which govern the carbohydrate metabolic pattern. Certainly, one of the important variables is the diet. Table 2 is a summary of the sugar equivalent intake (expressed in teaspoonsful) calculated from the dietary record.[5] The sugar intake at any one temporal point varied from zero to 28.9 teaspoonsful. Table 2 underscores the fact that the mean differences were significant in all instances except between the 8:15 A. M. meal (breakfast) and the mid-morning coffee break (9:30 A. M.). The variances were statistically significant only between the afternoon meals. Figure 2 graphically shows the mean sugar intake for the experimental days (white columns). The range for the group is approximately 29 teaspoonsful (0 to 29). It is reasonable to conclude, from these data, that the sugar intake fluctuates widely and significantly during the day in any one person and also varies considerably among individuals.

An analysis of Figure 3 shows the relationships between the ingestion of sugar and white flour foods and the blood glucose levels.

It appears from the available data that orderly relationships prevail between the dietary sugar equivalent intake and carbohydrate metabolism. In brief, after sugar intake, the blood glucose rises. Apparently, the glycemic responses are more severe following sucrose ingestion than after isoglucogenic quantities of other carbohydrates or protein.[6]

Question Three: While the observations thus far are of interest, no cause-and-effect relationships of sugar intake to blood glucose can be drawn.

Earlier mention was made of the fact that, on Monday through Thursday of the second week, the subjects were instructed to reduce sugar and white flour intake to a minimum. Table 3 summarizes the daily dietary sugar equivalent expressed in teaspoonsful.[5] In

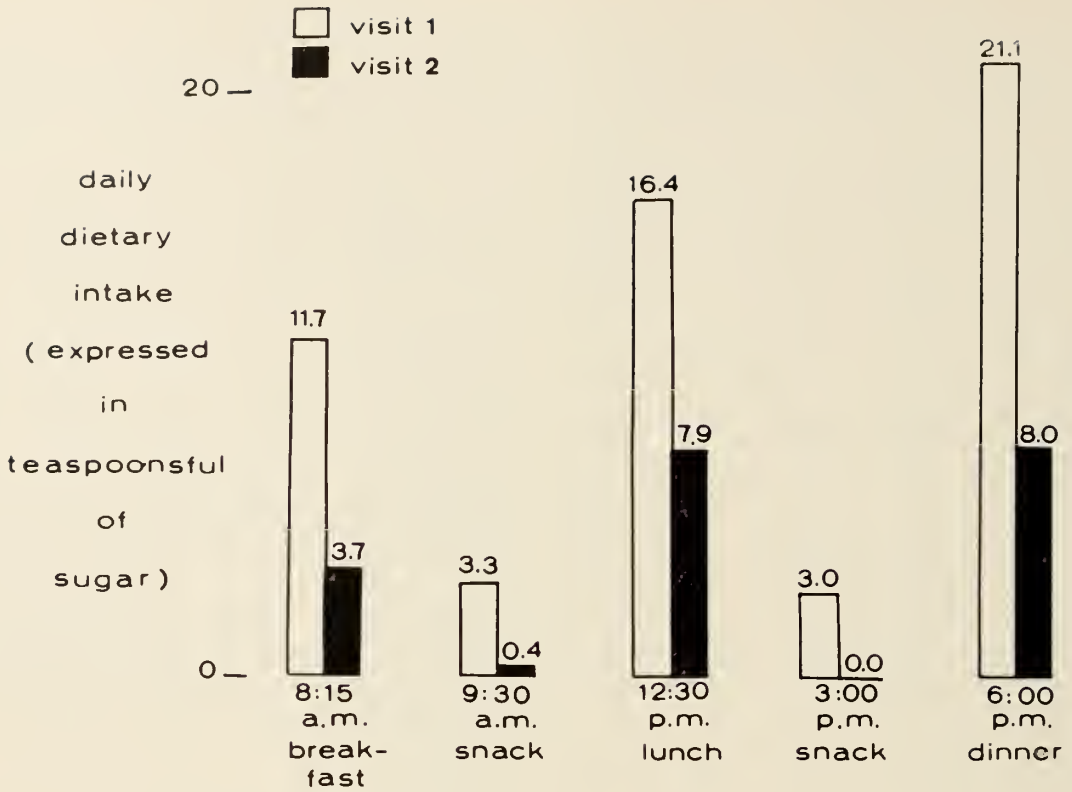


Figure 2. Mean sugar equivalent intake (expressed in teaspoonsful) after a three-day regular diet visit 1, white columns) and following a three-day reduction in refined-carbohydrate foods (visit 2, dark columns).

all instances, there are clearcut significant differences of the means and the variances. The mean sugar equivalent intake for the subjects at the initial (white columns) and the final visit (black columns) is summarized in Figure 2. It is abundantly clear from this chart that the sugar equivalent intake at every temporal point has been sharply curtailed. With this background information, it is now possible to reiterate the question as to what effect this dietary change exerted upon the blood glucose pattern.

Table 4 is a report of the individual and mean blood glucose values at each temporal point following the revised dietary regimen. The means are only significantly different in the morning hours. The variances are significantly different in the afternoon. Figure 1 shows the mean glucose values initially with a regular diet (interrupted line) versus the scores with a reduction in sugar equivalent intake (continuous line). On a regular diet, the mean spread of values is about 46 mg. per cent. At the second visit, the range is 20 mg. per cent. Hence, the mean spread has been cut more than in half.

It is now possible to answer the third question: what changes in carbohydrate metabolism occur with a dietary alteration? Within the limits of this study, it appears that significant blood glucose changes follow the elimination of refined-carbohydrate foods from the diet. Thus, the relative omission of sugars and white flour products seems to yield a more homeostatic picture of carbohydrate metabolism as evidenced by fewer and less abrupt fluctuations in the blood glucose concentration during the day. This is consistent with published reports.[6,7]

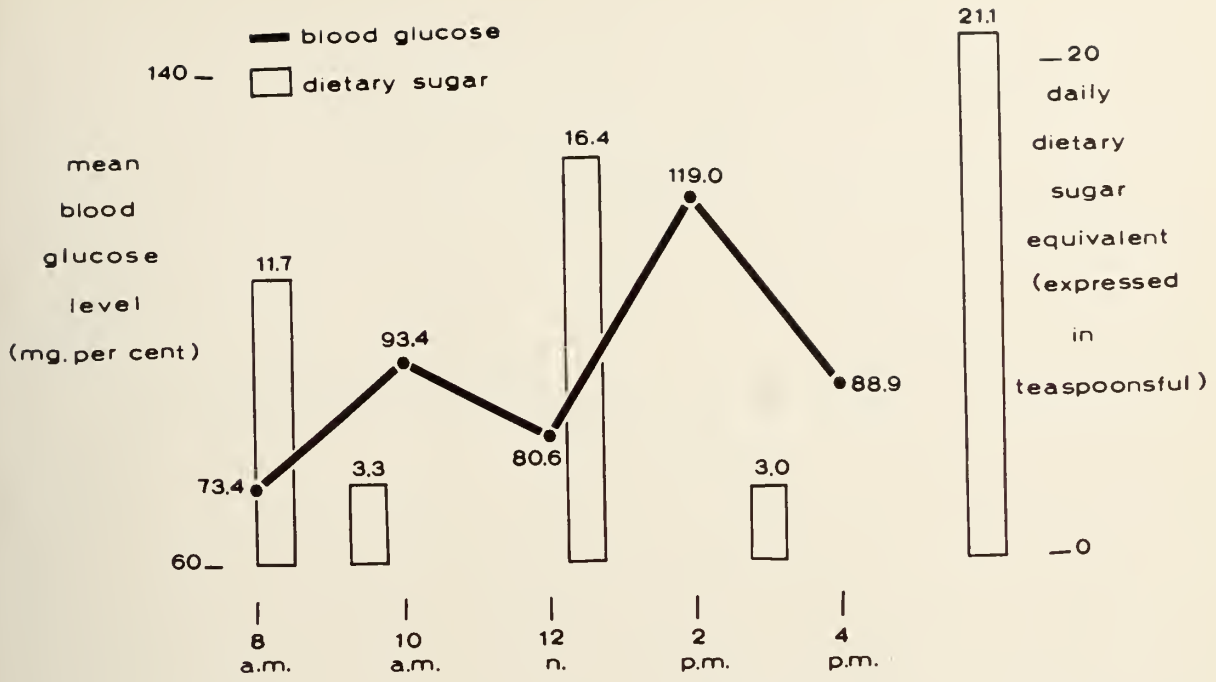


Figure 3. Relationship of the daily fluctuations in mean blood glucose (continuous line) to the mean sugar equivalent intake (expressed in teaspoonsful) of a regular diet (white columns).

Table 3

daily dietary sugar equivalent (expressed in teaspoonsful) during a three-day low-refined-carbohydrate dietary regime

subjects	8:15 A. M.	9:30 A. M.	12:30 P. M.	3:00 P. M.	6:00 P. M.
RiBl	1.7	0.0	5.6	0.0	4.6
BrSp	6.2	0.5	8.8	0.0	11.9
ShDu	3.8	0.5	11.7	0.0	8.8
YoKa	3.3	0.0	4.9	0.0	6.6
ThSh	0.0	0.5	7.3	0.0	7.4
WiGr	5.1	0.5	9.2	0.0	10.3
HeBr	5.5	0.5	7.9	0.0	6.4
mean	3.7	0.4	7.9	0.0	8.0
S. D.	2.3	0.2	2.3	0.0	2.5
range	0.0-6.2	0.0-0.5	4.9-11.7	0.0-0.0	4.6-11.9
significance of the difference of the means		<0.0050	<0.001	<0.001	<0.001
significance of the difference of the variances		$=0.0005$	$=0.0005$	$=0.0005$	0.0005

Table 4

blood glucose values in seven dentists following a three-day low-refined-carbohydrate diet

subjects	8:00 A. M.	10:00 A. M.	12:00 N.	2:00 P. M.	4:00 P. M.
RiBl	78	74	70	77	72
BrSp	76	69	77	110	90
ShDu	76	63	72	115	95
YoKa	90	80	80	70	70
ThSh	95	77	87	95	83
WiGr	100	65	87	82	92
HeBr	83	75	72	92	78
mean	85.4	71.9	77.9	91.6	82.9
S. D.	9.7	6.3	7.1	16.7	9.9
range	76-100	63-80	70-87	70-115	70-95
significance of the difference of the means		<0.010	>0.100	>0.050	>0.200
significance of the difference of the variances		$=0.100$	$=0.500$	$=0.005$	$=0.050$

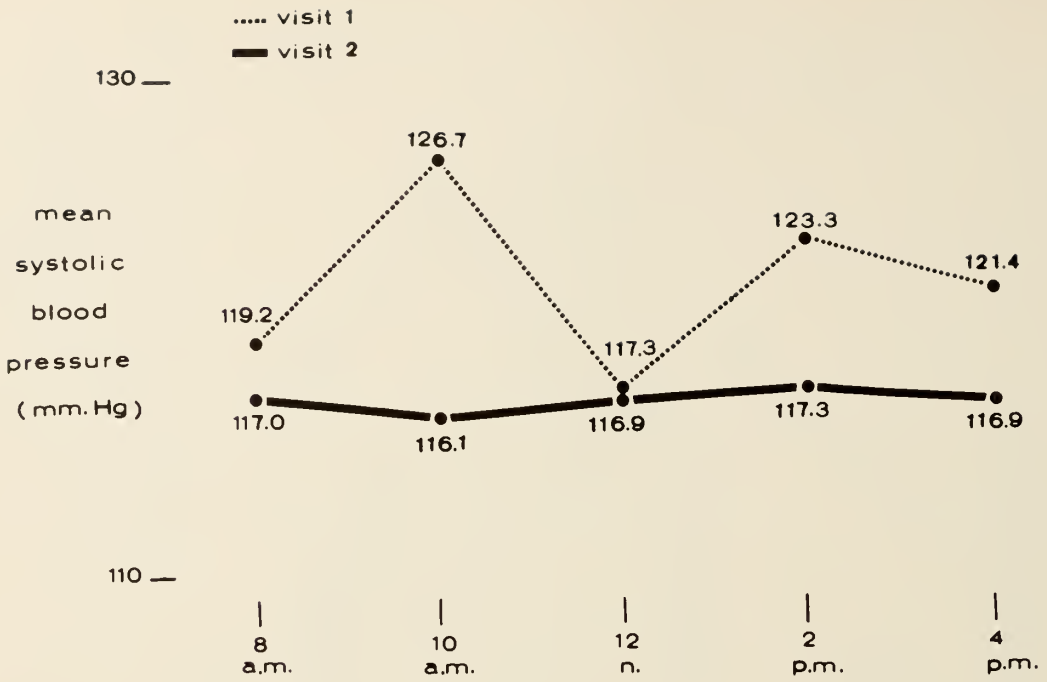


Figure 4. Daily fluctuations in mean systolic blood pressure following a three-day regular diet (visit 1, interrupted line) and after a three-day relatively low-refined-carbohydrate intake (visit 2, continuous line).

Question Four: The point now at hand is to determine whether the demonstrated changes in carbohydrate metabolism are of physiologic import. In other words, is the organism biologically better when there is a more homeostatic carbohydrate metabolic state?

Tables 5 and 6 summarize the systolic and diastolic blood pressure scores in the subjects singly and as a group while subsisting on a regular diet. It will be noted that the overall range is 43 mm. Hg for the systolic pressure and 39 mm. Hg for the diastolic pressure. Figures 4 and 5 pictorially portray the mean systolic and diastolic pressures respectively. It can be seen (interrupted lines) that the pressures fluctuate during the day in any one individual and that there are also variations among the subjects.

Figures 6 and 7 provide the opportunity of comparing the daily mean blood glucose and blood pressure changes while subsisting on a regular diet. It is interesting (Figure 6) that

Table 5

systolic blood pressure scores in seven dentists following a three-day regular dietary regime

subjects	8:00 A. M.	10:00 A. M.	12:00 N.	2:00 P. M.	4:00 P. M.
RiBl	—	122	114	122	120
BrSp	122	136	116	133	132
ShDu	135	140	130	133	134
YoKa	101	100	101	100	100
ThSh	120	140	134	143	130
WiGr	117	124	108	122	112
HeBr	120	125	118	110	122
mean	119.2	126.7	117.3	123.3	121.4
S. D.	10.9	14.1	11.6	14.7	12.2
range	101-135	100-140	101-130	100-143	100-134
significance of the difference of the means		>0.200	>0.200	>0.400	=0.500
significance of the difference of the variances		=0.500	=0.500	=0.250	=0.500

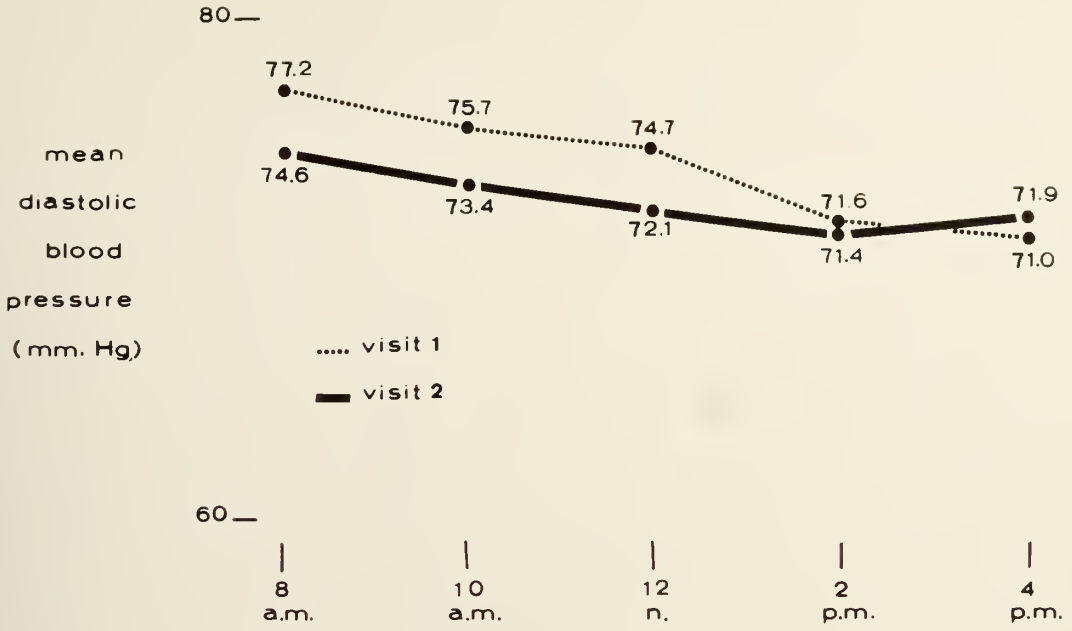


Figure 5. Daily fluctuations in the mean diastolic blood pressure subsequent to a three-day regular diet (visit 1, interrupted line) and following a three-day period of reduced refined-carbohydrate intake (visit 2, continuous line).

the systolic pressures at the various temporal points (continuous line) parallel almost precisely the fluctuations in blood glucose (interrupted line). This is not the case for diastolic pressure (Figure 7).

It is now possible to answer the fourth question: is there any relationship between carbohydrate metabolism and the physiologic state (e. g. blood pressure)? It would appear, from these data and an earlier study,[8] that parallelisms do indeed exist. Certainly, in the case of the systolic blood pressure, when the blood glucose rises, the systolic pressure increases; when the glucose decreased, the pressure drops.

Question Five: Now we may return to the all-important point. Is the organism biologically improved when the carbohydrate metabolic pattern is more steady?

The systolic and diastolic blood pressure readings following the dietary change are listed in Tables 7 and 8 respectively. Figures 4 and 5 provide the opportunity of comparing

Table 6

diastolic blood pressure scores in seven dentists following a three-day regular dietary regime

subjects	8:00 A. M.	10:00 A. M.	12:00 N.	2:00 P. M.	4:00 P. M.
RiBl	—	70	81	78	72
BrSp	70	64	64	62	63
ShDu	85	85	80	63	62
YoKa	81	78	72	80	78
ThSh	86	92	86	89	92
WiGr	70	75	70	76	70
HeBr	71	66	70	53	60
mean	77.2	75.7	74.7	71.6	71.0
S. D.	7.7	10.2	7.8	12.6	11.2
range	70-85	64-92	64-86	53-89	60.92
significance of the difference of the means		=0.500	=0.500	=0.500	=0.500
significance of the difference of the variances		=0.250	=0.250	=0.100	=0.500

the initial mean blood pressure values (interrupted lines) and the mean final scores (continuous lines). Mention should be made that, following the dietary change, the mean systolic range decreased from 10 mm. Hg (116.6 to 126.7) to about 1 mm. Hg (116.1 to 117.3). The spread for the diastolic readings shrunk from almost 10 mm. Hg (66.1 to 75.7) to 3 mm. Hg (74.6 to 71.4).

It is now possible to answer the fifth question: can the physiologic state (e. g. blood pressure) be significantly altered by reducing the intake of sugar and white flour foods? The answer appears to be in the affirmative.[8] With dietary change, the fluctuations in the individual subjects and for the group are fewer and the variations of smaller amplitude.

Table 7

systolic blood pressure scores in seven dentists following a three-day low-refined-carbohydrate diet

subjects	8:00 A. M.	10:00 A. M.	12:00 N.	2:00 P. M.	4:00 P. M.
RiBl	112	112	118	110	112
BrSp	122	124	122	126	125
ShDu	123	124	120	125	126
YoKa	108	102	107	104	103
ThSh	122	118	124	122	124
WiGr	114	116	110	114	114
HeBr	118	117	117	120	114
mean	117.0	116.1	116.9	117.3	116.9
S. D.	5.8	7.6	6.2	8.2	8.5
range	108-123	102-124	107-124	104-126	103-126
significance of the difference of the means		=0.500	=0.500	=0.500	=0.500
significance of the difference of the variances		=0.250	=0.500	=0.250	=0.500

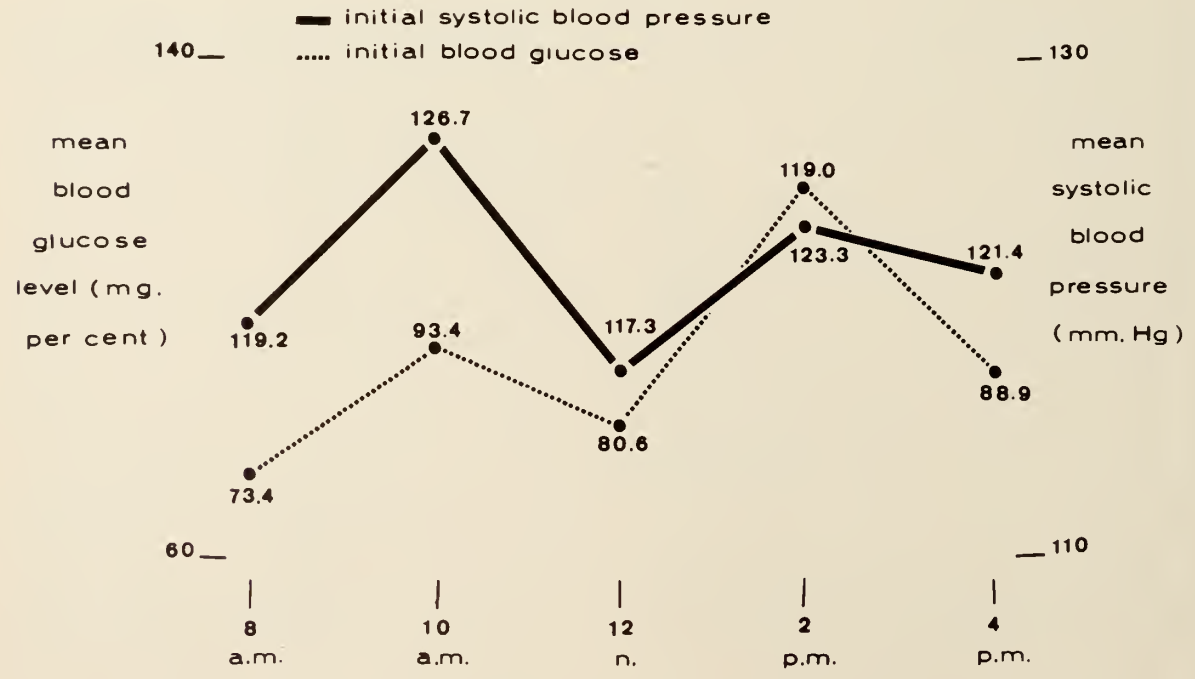


Figure 6. Comparison of the daily variations in the mean blood glucose (interrupted line) and the mean systolic blood pressure (continuous line) after a three-day regular dietary regimen.

Table 8

diastolic blood pressure scores in seven dentists following a three-day low-refined-carbohydrate diet

subjects	8:00 A. M.	10:00 A. M.	12:00 N.	2:00 P. M.	4:00 P. M.
RiBl	70	70	71	70	68
BrSp	74	70	67	66	70
ShDu	78	74	73	74	74
YoKa	80	80	72	72	72
ThSh	82	80	82	80	83
WiGr	70	72	68	70	68
HeBr	68	68	72	68	68
mean	74.6	73.4	72.1	71.4	71.9
S. D.	5.5	4.9	4.9	4.6	5.4
range	68-82	68-80	68-73	68-80	68-74
significance of the difference of the means		=0.500	=0.500	=0.500	=0.500
significance of the difference of the variances		=0.250	=0.500	=0.500	=0.500

Discussion

Much has been written about the mechanisms which control homeostasis (the steady state). Relatively little attention has been accorded the study of how steady is the steady state. Dubos,[9] in his writings about Claude Bernard and homeostasis, made the following statement:

He (Claude Bernard) emphasized that at all levels of biological organization, in plants as well as in animals, survival and fitness are conditioned by the ability of the organism to resist the impact of the outside world and maintain constant *within narrow limits* (italics added) the physicochemical characteristics of its internal environment.

Surely, during health, body temperature fluctuates during the day. Any sudden rise or abrupt fall is immediately reflected in the clinical state (e. g. sweating and chilling). Ordinarily, the average man during the usual

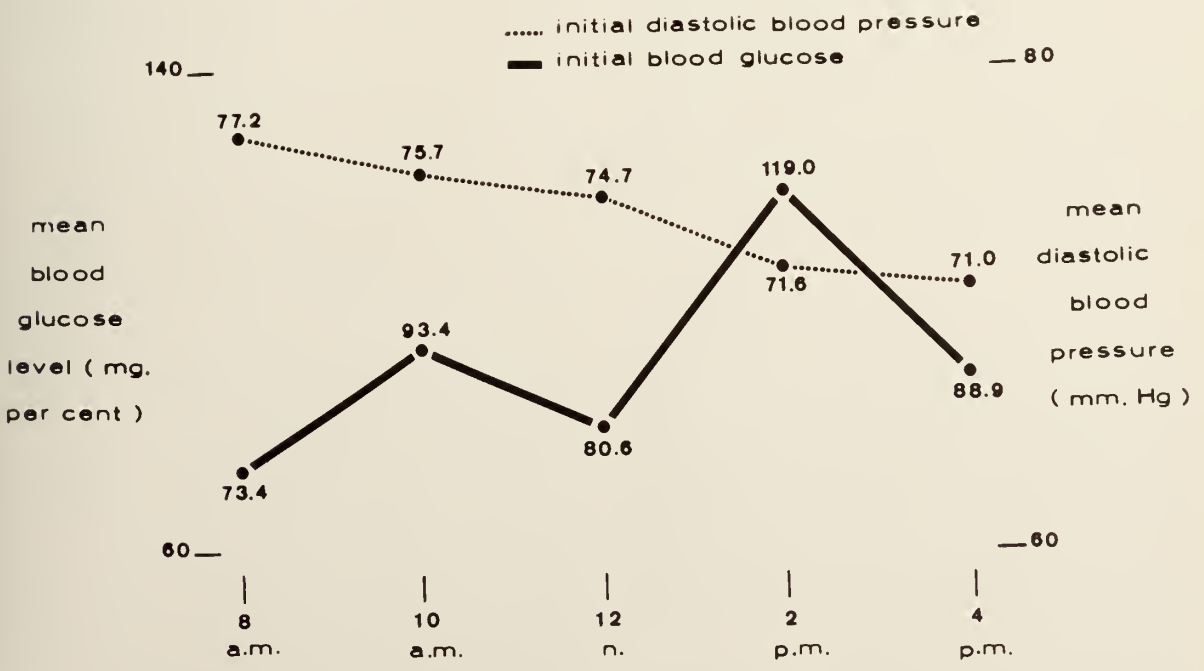


Figure 7. Comparison of the daily fluctuations in mean blood glucose (continuous line) and the mean diastolic blood pressure (interrupted line) after a three-day regular diet.

day has his moments of pleasure and displeasure. When these fluctuations are exaggerated so that the subject is at once manic and moments later catatonic, disease is obvious. It would seem that health and disease could be plotted on the basis of the extent of the amplitudes of a constellation of physiologic, biochemical and clinical parameters. It would appear that carbohydrate metabolism (as reflected in blood glucose) also possesses its physiologic limits. Thus, during the normal day for the healthy man, blood glucose should vary. The question is how much amplitude is physiologically acceptable.

This study shows that a daily blood glucose variation exists. This experiment demonstrates that the blood glucose concentration parallels dietary habits. In this report there is evidence to indicate that the ups and downs in blood glucose can be reduced by decreasing the sugar and white flour intake. Thus, as far as carbohydrate metabolism is concerned, the end-result is a more steady state, a more homeostatic pattern.

That this biochemical phenomenon is not without physiologic benefits is demonstrated by a study of the cardiovascular system as reflected in blood pressure. Daily fluctuations are evident in the average man. These blood pressure changes correlate with the blood glucose levels. The restriction of sugar and white flour products seems to parallel a more steady state in the cardiovascular system as reflected by the blood pressure.

Summary

In the final analysis, life or death is a function of homeostasis. When the homeostatic machinery collapses, host susceptibility replaces host resistance. The previously innocuous environmental challenges now overwhelm the system and disease and then death ensue.

A study of the steady state as measured biochemically by blood glucose and clinically by blood pressure is described. Normally, both blood glucose and blood pressure fluctuate during the day. These patterns parallel the intake of refined-carbohydrate foods. With a reduction in dietary sugar and white flour foods, the fluctuations in both blood glucose and blood pressure diminish.

It is postulated that this more steady, more homeostatic, state is beneficial to the survival of the organism.

References

1. Krasnyanskii, L. M. Variations in the blood sugar concentration in man in the course of the day. Biochem. Z. 205, 180-185, 1929.

2. Meyer, F. A. Blood sugar behavior in normal metabolism. I. Blood, sugar behavior and daily rhythm. Z. ges. exptl. Med. 107, 569, 582, 1940. Abstract Chem. Abst. 36, 6221, 1942.

3. Jonas, L., Miller, T. G. and Teller, T. All day blood sugar curves in non-diabetic individuals and in diabetic patients with and without insulin. Arch. Int. Med. 35, 289-314, 1925.

4. Adamkiewicz, V. A. A new view of the old cold—as sugars go up, hypersensitivity drops. J. A. M. A. 184, 40-41 (Medical News), 18 May 1963.

5. Council on Dental Health. Philadelphia County Dental Society. A sweet tooth can spoil a sweet smile. Philadelphia, Pennsylvania 1958.

6. Conn, J. W. and Newburgh, L. H. The glycemic response to isoglucogenic quantities of protein and carbohydrate. J. Clin. Invest. 15, 665, 671, 1936.

7. Page, M. E., Ringsdorf, W. M., Jr. and Cheraskin, E. The effect of a low-refined-carbohydrate high-protein diet upon nonfasting blood sugar. Odont. Revy 12, 1-24, 1961.

8. Ringsdorf, W. M., Jr., Cheraskin, E. and Hollis, C. F. Effect of a low-refined-carbohydrate diet upon non-fasting blood pressure. Ala. Dent. Rev. 9, 18-30, Spring 1962.

9. Dubos, R. Mirage of health. 1959. New York, Harper and Brothers. P. 100.

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The Status Of Clinical Kidney Homotransplantation–Spring, 1965

J. Walden Retan, M. D.

Renal Division, Department of Medicine
University of Alabama Medical Center
Birmingham, Alabama

"When she was good, she was very, very good, and when she was bad, she was horrid."

Anonymous

The purpose of this paper is to provide answers to three frequent questions about clinical renal homotransplantation:

1. What are the chances that the patient will survive the procedure?

2. What is the quality of life of the recipient of a renal homograft?

3. When and how does one refer a patient for renal homotransplantation?

The Chance of Survival

Statistical answers to the first question are beginning to appear in abundance. With the support of the National Academy of Sciences and the National Research Council, an international registry of data on human kidney homotransplantation has been developed. Statistics are gathered from investigators across the world and are published periodically in the journal *Transplantation*. The most recent compilation was published in March, 1965;[1] it will be brought up-to-date about every six months. In the recent compilation, 495 renal homografts were recorded. One hundred and ninety-six of the recipients were alive, for an over-all world-wide success of 39.6 per cent.

While these figures provide a preliminary estimate of what the patient and doctor may expect, they require substantial qualification.

On one hand they are too optimistic, for two reasons. They include the figures for identical twin homografts where no immunologic barrier to the success of the graft exists. Even in identical twin experience, a graft may not be curative, however, for the original disease may recur in the grafted kidney. The over-all figures also include patients whose homografts had been performed within a relatively short period of time before the statistics were collected; too short a time, in fact, for the benefits of the graft to be decided.

On the other hand the statistics provide an unnecessarily gloomy outlook for what selected patients may expect. They include a substantial number of transplantation efforts and transplantation failures carried out prior to the current era of drug therapy which began in early 1962. They also include in one large number both the experience of centers where grafts are expertly performed and that of other centers where mortality rates are excessive.[2] As will be noted subsequently, success rates vary widely depending on the relationship between donor and recipient, and on whether the donors are living or dead.

Finally, the statistics are misleading since changes in technique and acquisition of experience are occurring at a rapid rate. Over two-thirds of the 495 transplants performed and reported to the Kidney Transplant Registry had occurred in the 18 months ending September 15, 1964. By the time that experience was published in March, 1965, and is summarized in this article a much wider experience will have been obtained, with near certain improvement in patient prognosis. In this sense, the best and most recent figures published are obsolete before they appear in print.

The freshest data from the largest, single series of patients have recently been reported by Starzl.[3, 4] His first 64 consecutive non-twin recipients of kidneys from living donors were all operated upon more than one year prior to this report. Of the group of 64, 56 per cent are presently surviving. Within this group, when the kidney donor was unrelated to the recipient, only five of 18 of the recipients are alive, while 31 of 46 of the recipients of a kidney from a relative are surviving.

The Quality of Life

There is no dispute that the quality of life of a renal homograft recipient is as important as its quantity in determining whether a patient should be subjected to the procedure. On one hand one would hesitate to reduce a patient to an existence that required him spending the rest of his life in a hospital or in an environment protected from any possible contact with infectious diseases. Fortunately, contemporary drug therapy does not require this type of care. On the other hand it has been stated that "some recipients are leading normal lives with minimal or no adverse side effects. They are not immunological cripples. They are working full-time, living useful lives at home with their families and taking drugs by mouth with no more inconvenience than ingesting vitamin pills."[1] While this is a fair description of the lives of some patients, others are partially or totally disabled by complications of their treatment. Most grafted patients are maintained on prolonged immunosuppressive drug therapy involving a combination of prednisone with a derivative of 6-mercaptopurine. Many of them experience the side effect of prolonged steroid therapy, including gastric and duodenal ulcers, osteoporosis, diabetes, increased susceptibility to viral, fungal and bacterial infections (particularly including tuberculosis) and Cushingoid disfigurement. They may be subject to homograft rejection crises for many months after the kidneys are in place and may also encounter the recurrence of their original kidney disease in the grafted kidney. Some recipients have undergone a peculiar wasting disease characterized by marked anorexia and tissue catabolism possibly related to runt disease in animals. Others who have received kidneys from cadaver donors have discovered that the cancer and infectious diseases can be transplanted from one individual to another with the same freedom that the kidney can. These by no means complete the list of potential complications of therapy.

While it is relatively simple to describe the potential morbidity associated with homotransplantation, it is much more difficult to quantitate morbidity for recipients as a whole or to predict it for any given patient. About all one can say that is generally true is that life for most recipients is of thoroughly acceptable quality, but not entirely normal. Almost all are able to return to their homes, their schools or their jobs. They are almost always free of the dietary restrictions and the sense of dependence on a machine that is a part of chronic hemodialysis therapy. On the other hand, all are subject to the threat of delayed, sometimes sudden, sometimes lethal complications of therapy or rejection, though the risks of catastrophe decrease markedly the longer one survives with his grafted kidney. Most of the complications are treatable. However, diagnosis and treatment of many of the complications require skills and services that are found in relatively few medical centers, and may make it necessary that the

patient move near the center where his graft is performed, at least temporarily.

Whether, How, When, and Where to Refer

The decision *whether* to refer a patient for renal homotransplantation is deeply disturbing, for it involves both the welfare of the recipient and that of a donor. From the standpoint of the recipient alone, renal homograft surgery in some centers now offers the prospect of palliation of renal disease (palliation, not cure) that is comparable or superior to the results of some common cancer surgery. Whether the results now justify the small but definite risk to the donor, or whether the use of a living donor is ever justified is a matter to be decided between one's self and one's own conscience.

If the referral is seriously considered, there is a growing medical and surgical literature on the techniques, results, complications and prospects of renal homotransplantation to aid the decision. For greater depth, Starzl's monograph[4] has been cited and Moore[5] has written a short book intended specifically for patients and families about to experience homotransplantation and for their referring physicians. The registry of renal transplantation experience[1] may be consulted both for up-to-date statistical experience and for the names and addresses of physicians performing the procedure throughout the world. In passing, there is a notable difference in the impression one gathers of the present state of the art of transplantation when these sources are contrasted with the picture of transplantation painted in the lay press.

Criteria for patient acceptance vary widely between centers. In some, for example, cadavers are the only source of kidneys used. In others, the superior success rates with living related donors are thought to justify the risks involved. However, despite the difference between centers, a few generalizations can be made that will apply to most, if not all:

1) Prospective recipients should be free of non-renal diseases such as tuberculosis, cerebral vascular disease, diabetes, ulcers and carcinomas that would seriously affect their prognosis. They must also be uninfected, free of urinary tract obstruction, and either reasonable operative risks in the conventional sense, or able to be made so by dialysis. The patient's age and the availability of a donor may affect the decision.

2) Prospective donors must be good operative risks, free themselves of hypertension and kidney disease, and volunteers operating without coercion or expectation of reward. While some successful grafts have been performed in spite of major blood group incompatibility, most centers now only accept donors whose red cells are compatible with the recipients serum.

3) Prospective recipients should be given every possible opportunity to benefit from conservative therapy, but on the other hand, they must be referred before they are moribund. While this is true for living donor homografts, it is especially true if a cadaver graft is contemplated, for the wait for a suitable kidney may be protracted, and the demand for cadaver kidneys usually exceeds the supply.

4) Finally, when a long and expensive surgical procedure is considered, it may be important to know that some centers have grants that partially defray the costs of the hospitalization.

Summary

At best, a renal homograft recipient may expect better than a 50 per cent chance of one year or more survival with a kidney from a related living donor. The additional life afforded by the graft may be adversely affected by episodes of rejection or by complications of immunosuppressive drug therapy, but it is usually of acceptable quality. The problems of whether, when and how to refer a prospective patient are discussed.

References

1. Murray, J. E.; R. Gleason, and A. Bartholomay: Second Report of Registry in Human Kidney Transplantation. Transplantation 2: 660, 1964.

1a. Murray, J. E.; R. Gleason, and A. Bartholomay: Third Report of Registry in Human Kidney Transplantation. Transplantation 3: 294, 1965.

2. Morelle, J.; G. Alexandre; P. Michielsen, and Ch. van Ypersele: Le probleme de la greffe renale. Bull. Acad. Royal Med. Belgique 4: 156, 1964.

3. Starzl, T. E., and T. Marchioro: Personal Communication.

4. Starzl, Thomas E.: Experience in Renal Transplantation. W. B. Saunders, Philadelphia, 1964, 383 pp.

5. Moore, Francis D.: Give and Take: The Development of Tissue Transplantation. W. B. Saunders, Philadelphia, 1964, 182 pp.

Proposed Program Could Damage Medical Care

The recently proposed national program to "conquer" heart disease, cancer and stroke could seriously damage the present system of American medical education and medical care, the American Medical Association asserts in a critique published in the current (April 26) Journal of the AMA.

The whole proposal evolves from two undocumented and controversial assumptions, according to the AMA. These are: (1) that American physicians are unable to keep abreast of and apply new medical knowledge, and (2) that more money should be spent on medical research to find new concepts applicable to the treatment of disease. If data are available to substantiate either assumption, the medical organization asked that it be made available to the medical profession and the public.

Recommendations for a federally financed national program were worked out over a period of several months by the President's Commission on Heart Disease, Cancer and Stroke, a 28-member body of laymen and physicians headed by Dr. Michael DeBakey of Baylor University, Houston, Texas.

When President Johnson appointed the commission early in 1964, he charged it with the task of finding ways to reduce "the incidence of these diseases through new knowledge and more complete utilization of the medical knowledge that we already have."

The report of the commission in December raised many more questions than it answered, says the AMA. In essence, the medical organization declares, the commission proposes to reorganize the American system of delivering medical care to the patient and the way in which the American physician and scientist are educated.

According to the commission report, the frequency of heart disease, cancer and stroke could be reduced by adopting 35 recommendations and 11 separate proposals for legislation. While these cover nearly every facet of medicine and related activities, the principal features of the multi-billion-dollar program are proposals for:

(1) The creation of 60 regional complexes for care and clinical investigation of patients with heart disease, cancer and stroke.

(2) Research institutes within existing hospitals and medical schools, to investigate both disease-related and noncategorical problems.

(3) The establishment of 550 diagnostic and treatment stations for the three diseases.

(4) Increasing manpower in both clinical and research medicine by expanding current programs supported by the federal government and creating new ones.

Legislation generated by the report is al-

ready in Congress and hearings have been held by a Senate committee.

"The commission is, in effect, taking the position that it is impossible to achieve optimum control of heart disease, cancer and stroke without a broad and sweeping revision of our present system," the AMA points out. It is this system, it adds, that "although always subject to improvement, has produced the best medical education in the world, the most sophisticated diagnostic and therapeutic advances, and the most advanced understanding and treatment of disease processes."

Stating that the existing medical system offers every reasonable expectation for further advances, the AMA challenges the commission and its congressional supporters to show that the proposed changes will better and not damage the system.

The federal government already is responsible for serious fragmentation of U. S. health care services by "the development of multiple non-coordinated health care programs administered by multiple federal agencies. . . ."

The report of the commission, setting forth a new health service program, can only compound the problem, in the eyes of the AMA. The commission's recommended program, it says, totally disregards traditional relationships and responsibilities of state and local health departments, voluntary agencies and communities in favor of a "centrally planned" approach to medical care.

In questioning the commission's premise that an outpouring of federal funds for "research" will lead to "conquest" of disease, the AMA observes that money does not buy knowledge. Crash programs requiring huge expenditures—such as the Manhattan Project—are indicated only when basic knowledge and theory are well advanced.

While money may fill laboratories with scientists, the medical organization says, it cannot significantly increase the always small number of creative scientists who advance basic knowledge through their individual insights. This relative scarcity of creative scientists "makes the program advanced by the commission a false and hollow expectation."

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OCTOBER

Symposium on COMMON PROBLEMS IN GENERAL PRACTICE—OFFICE PROCEDURES. Mound Park Hospital Foundation, Florida Academy of General Practice—(16th Annual Scientific Assembly)—October 29 and 30, 1965—registration 12:00 to 5:00 P. M., October 28th. The Foundation reserves the right to limit registration. By special arrangement—NO REGISTRATION FEE. 14 Accredited Hours by the American Academy of General Practice. Address—GENERAL PRACTICE, Mound Park Hospital Foundation, Inc., St. Petersburg, Florida 33701.





BOARD OF TI

Handling Association business is not an easy job, as evidenced by the pictures on these two pages. In the top two pictures, Mr. Jerry Gould, AMA Field Representative, reports on federal legislation.

Even when in Montgomery Dr. John Chenault, left, keeps in touch with his patients in Decatur.

"They also serve who only sit and wait." Shown below are Mrs. R. M. Miller, Mrs. James G. Donald, and Mrs. F. M. Phillippi, Jr.







TEES MEETING

Dr. William L. Smith and Dr. Paul W. Burleson, right, taking a break from a day-long meeting.



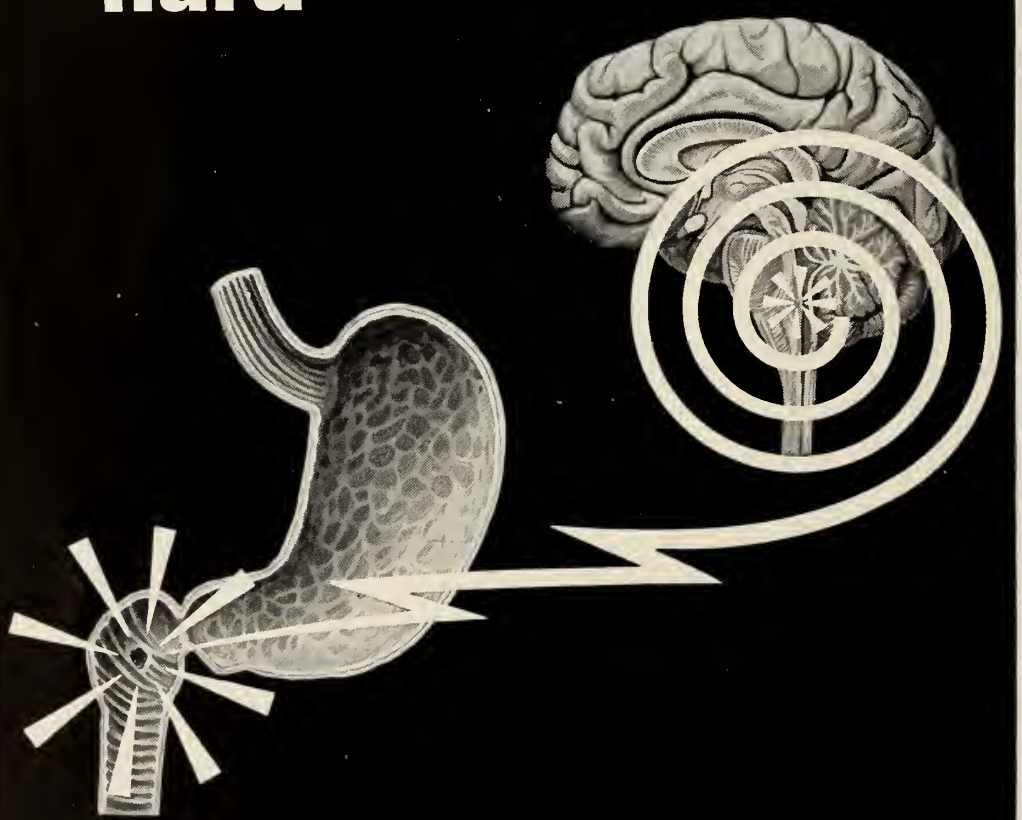
Below left, Dr. H. G. Hodo, Dr. E. B. Glenn, and Dr. James G. Donald, go over notes.





Executive secretary, Mr. W. V. Wallace, after the meeting, wonders how long it will take to clear his desk for action again.

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Research in the Service of Medicine



PATHOLOGY FORUM

The Family Physician And Cervical Carcinoma --- Challenge And Opportunity

Edmund A. Dowling, M. D.*

When Papanicolaou and Traut published their monograph on exfoliative cytology in 1943 a new era began in the diagnosis and treatment of carcinoma of the cervix. The impact was twofold. First, there were the fruits of the direct application of the technic to detection of cancer at a stage when it was non-invasive and, secondly, the interest in prophylaxis aroused by the new method lead to examination and diagnosis in many patients who harbored an invasive but unsuspected cervical neoplasm. In the 22 years which have elapsed since the debut of exfoliative cytology as an accepted diagnostic tool enthusiastic reports have documented the changing patterns of cervical carcinoma which have emerged as the result of diagnostic programs in many institutions and communities. The trend has been demonstrated to be both in the direction of earlier recognition of invasive carcinoma and reversal of the ratio of invasive to non-invasive neoplasm. It would be reassuring indeed if such trends should prove to be of general validity, reflected by decline in mortality and morbidity at state and national levels. However, it is discouraging to find that the mortality from cervical carcinoma in the United States has shown no significant decline during a decade or more of steadily mounting emphasis on regular gynecologic examination including the cytologic approach.

Morbidity and mortality from cervical carcinoma constitute a leading cancer problem for Alabama. The American Cancer Society estimates that 1,000 cases of uterine cancer occurred in Alabama in 1964, the majority of which neoplasms were cervical. Such incidence exceeds that of any other extra-cutaneous site including colon and rectum. Public Health Service figures for the year 1960[1] show Alabama leading all other states in terms of mortality from carcinoma of the cervix. The average adjusted death rate (per 100,000 population) for Alabama is 15.4 while the national average is 8.4.

Reasons for this unenviable distinction are undocumented but some pertinent facts may be gleaned from inspection of available data. Prevalence of carcinoma of the cervix has been related to socio-economic status, sexual hygiene, age at first intercourse and, as a derivative of the previous factors, race. A combination of high risk and delay in diag-

*Dr. Dowling is Associate Professor of Pathology and Director of Surgical Pathology, University of Alabama Medical Center.

nosis and/or treatment sets the stage for high mortality rates. Figures available for Jefferson County during the year 1960[2] show mortality 50 per cent in excess of the national average. In the female population 15 years and over 18.3 per cent of cases were fatal. In non-whites 25.5 per cent were fatal. The highest mortality was in non-white females 65 years or older (35.7 per cent). It is in this last group, experience teaches, that delay in diagnosis and treatment is most likely to prevail.

Mass community surveys using cytology as the primary tool for the recognition of early cervical cancer have produced rewarding results. Such a survey conducted in Shelby County, Tennessee[4] lead to the detection of three cases of invasive cervical carcinoma per thousand women examined and four cases per thousand of carcinoma in situ. Cytology was sufficiently new at the time of the Shelby County survey so that the figures give an estimate of the actual prevalence of cervical cancer in that community. The high yield of invasive carcinoma was a gratifying result particularly since pelvic examination was not a routine part of the protocol. Women from the same program, cytologically negative on the first examination, when re-examined one year later were found to have only 0.3 cases of invasive carcinoma per thousand in contrast to two cases per thousand of carcinoma in situ. These latter figures provide an estimate of the incidence of carcinoma in the community.

Highly publicized mass cytologic surveys for cervical carcinoma, however, are not the final answer to the problem since interest is likely to wane on the part of women once the program ends. Indeed a false sense of security may be imbued on the basis of a single negative examination alone. The family physician, on the other hand, is in a strong position to bring the benefits of cytologic examination to many women who may not regularly present themselves to the gynecologic specialist for evaluation. Any office visit by a patient may be an opportunity for obtaining an important cytologic sample. Not to be excluded are young women who may be introduced to the annual smear routine when seen in pregnancy. Twenty years is an accepted age for beginning cytologic examinations, but younger women who have begun active sex life should also be included.

We have already indicated that mortality rates from cervical carcinoma have not shown significant decline nationally despite emphasis for more than two decades on the value of cytologic diagnosis. We may explain this discrepancy, at least in part, in terms of the limited impact of cytology on the total population. As recently as 1963 only 15 per cent of women 20 years or over were examined cytologically in the United States. In Alabama, the State with the highest mortality from cervical carcinoma, 16 per cent of the population was examined while, curiously, in North Dakota, the State lowest in cervical cancer mortality, cytology had been availed of by only eight per cent of the population. It is clear that the desired benefits of early diagnosis, achievable by cytologic means, can be realized in high risk communities only if the technic is made available on a regular basis to a large percentage of the population. The inadequacy of examining only 15 per cent of the population annually is underscored when it is realized that, for the most part, it is the same women who are re-examined from year to year and that these patients are likely to rank in the socio-economic group least at risk. While for many women the gynecologist and the family physician ideally provide the continuing stimulus for this form of cancer prophylaxis it is clear that the benefits of early cytologic diagnosis also need to be expanded so as to include socio-economic groups who are deprived of regular medical attention but who are most at risk in our society both in terms of morbidity and mortality.

Greatly expanded cytologic services are predicated on adequate laboratory facilities and staffing. The diagnostic team in the laboratory is directed by pathologists who have special interest and experience in the field of cytopathology and ideally includes well-trained cytotechnologists some of whom should be of sufficient seniority to act as sup-

ervisors and teachers of the less experienced. Schools of cytotechnology should be adequate to serve the needs of pathologists in the state. Under conditions of rapid expansion of services the weakest link undoubtedly would be our ability to recruit adequate numbers of suitably educated and motivated personnel to train and work as cytotechnologists. It has been estimated that 5,000 cytologic specimens were examined per cytotechnologist in the United States in 1963.[3] Senior cytotechnologists might double this output but such experience is in short supply. Additional cytotechnologists necessary to examine smears from all women age 20 and over in Alabama are estimated at 126. In the year 1965 only five cytotechnologists will have been trained in the state. Physicians of the state can do much by their advice and encouragement to help that recruitment in the paramedical fields on which the future of laboratory services and medicine depends so heavily.

References

1. Age-adjusted and Age-specific death rates for malignant neoplasm 1960. U. S. Department of Health, Education and Welfare. Public Health Service Publications No. 1113, 1963.

2. Cancer of cervix: deaths U. S. and Jefferson County 1956-60. Bureau of Vital Statistics, Jefferson County Department of Health, 1962.

3. Christopherson, W. M. A survey of cytopathology facilities in the United States. Bulletin College of American Pathologists, June 1965.

4. Erickson, C. C., Everet, B. E., Jr., Graves, L. M., Kaiser, R. F., Malmgren, R. A., Rube, I., Schreier, P. C. and Cutler, S. J. Population screening for uterine cancer by vaginal cytology. J. A. M. A. 162: 167-173, 1956.

The JOURNAL neglected to give full credit for the paper on "Supravalvular Aortic Stenosis and Facial Anomalies—A Recently Described New Syndrome," which appeared in the August issue—Pathology Forum. Credit for authorship should have been accorded equally to Ricardo Ceballos, M. D., and Norman Sudduth, M. D., Associate Professor and Trainee Resident, Department of Pathology.

The JOURNAL has been asked to state also that the paper was supported by a training grant from the United States Public Health Service.

ALABAMA
DIABETES ASSOCIATION

SYMPOSIUM ON
DIABETES MELLITUS

SEPTEMBER 19, 1965

PARLIAMENT HOUSE
BIRMINGHAM, ALABAMA

Alabama Department of Public Health

Ambulances And Emergency Medical Care

The availability of effective emergency medical care while being transported to the nearest physician or hospital for definite treatment is an absolute necessity for every citizen. If patients are to receive the benefits of the great technical strides made in surgical and medical treatment, they must be transported safely.

The Accident Prevention Program of the Alabama Department of Public Health recently completed a survey to determine the quality of emergency medical service available. Forty-five establishments were surveyed in counties of less than 50,000 population. The survey was designed to determine the training held by the attendants and the type of equipment available in vehicles for administering basic first aid.

Unfortunately, the survey indicated that an Alabama citizen requiring emergency medical transportation in the rural areas will normally have untrained attendants and ill-equipped vehicles servicing his needs. For example, only 32 per cent of the 188 employees surveyed had completed an advanced Red Cross first aid course or its equivalent. Only 44 per cent of the surveyed ambulances had any type of oxygen-breathing apparatus available in the vehicle. These two examples indicate that the quality of ambulance service available is in need of serious change if Alabama's citizens are to receive proper emergency care prior to reaching the physician or hospital emergency room.

The following reasons were often given by the ambulance operators for this deplorable situation which now exists in our state.

(1) Low wages and long hours have resulted in a high turnover of personnel.

(2) The background and training of potential employees rarely assures the operator that appropriate skills and attitudes will be brought to the job.

(3) Ambulance operators are unable to collect payment for services rendered.

(4) The costs of proper equipment are extremely high in relation to the investment return.

The lack of adequate personnel was evident in the survey with an average of 1.8 attendants available per vehicle. Obviously there are ambulances being operated with only the driver available to assist the patient and operate the vehicle. Certainly a minimum of one driver and one attendant should be required on all calls. It is impossible for one person to provide adequately the assistance required by a sick or injured person.

Licensing of various medical personnel has

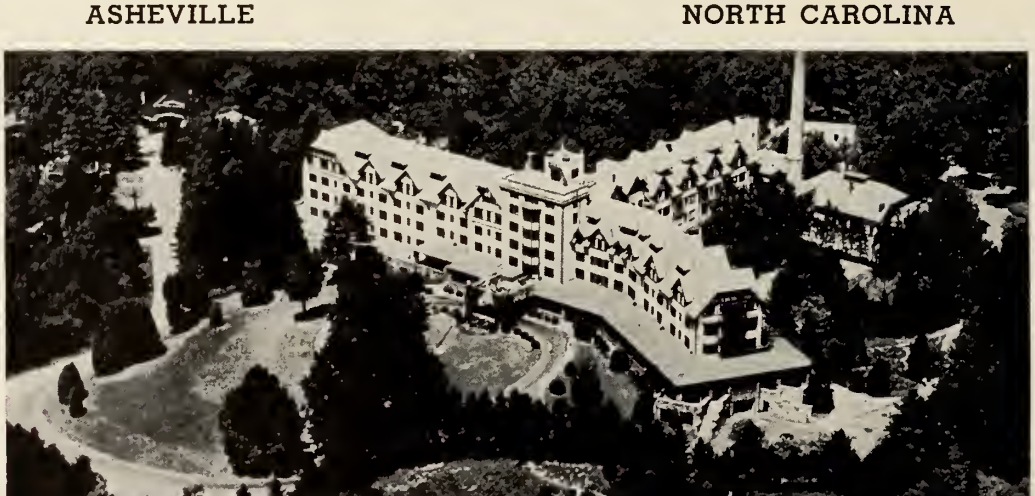
been a practice for many years. Persons working in emergency medical service are in a medically related field and certainly should be required to have at least the equivalent of an advanced Red Cross first aid course. Emergency vehicles should have sufficient equipment such as splints, stretchers and oxygen equipment.

If the present trend continues and the emergency medical service business does not become more profitable for the owners, we will continue to have poorly trained attendants and ill-equipped vehicles. The physician as a member of the county medical society could be most effective in determining the quality of service available locally. Upon identity of the problem the most practical approach would be to support an ordinance designed to regulate the emergency medical service. When necessary the county medical society could provide the leadership in bringing before local government bodies the need for supplemental funds to provide a well trained and properly equipped emergency medical service within your community.

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Wm. Ray Griffin, Jr., M. D.
Robert A. Griffin, M. D.

Mark A. Griffin, Sr., M. D.
Mark A. Griffin, Jr., M. D.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

July 1965

Examinations for intestinal parasites	1,472
Typhoid cultures (blood, feces, urine and other)	267
Examinations for malaria	5
Examinations for gonococci	1,975
Serologic tests for syphilis (blood and spinal fluid)	29,802
Agglutination tests	10
Examinations for diphtheria bacilli and vincent's	102
Examinations for Negri bodies (smears and animal inoculations)	299
Complement Fixation	153
Water examinations	2,774
Milk and dairy products examinations	3,959
Examinations for tubercle bacilli	3,849
Miscellaneous examinations	7,691
Total	52,358

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

July 1965

Examinations for intestinal parasites	1,589
Typhoid cultures (blood, feces, urine and other)	425
Brucella cultures	1
Examinations for malaria	5
Examinations for gonococci	1,925
Serologic tests for syphilis (blood and spinal fluid)	26,966
Darkfield examinations	1
Agglutination tests	20
Examinations for diphtheria bacilli and vincent's	52
Examinations for Negri bodies (smears and animal inoculation)	283
Complement Fixation	331
Water examinations	3,173
Milk and dairy products examinations	3,756
Examination for tubercle bacilli	3,493
Miscellaneous examinations	7,864
Total	49,884

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

CURRENT MORBIDITY STATISTICS

1965

	May	June	*E. E. June
Tuberculosis	146	121	136
Syphilis	195	334	137
Gonorrhea	284	433	302
Chancroid	1	0	4
Typhoid fever	0	1	1
Undulant fever	0	0	1
Amebic dysentery	5	2	3
Scarlet fever & strep. throat	200	138	39
Diphtheria	0	2	1
Whooping cough	5	13	34
Meningitis	6	8	6
Tularemia	0	0	0
Tetanus	2	1	2
Poliomyelitis	0	0	1
Encephalitis	1	0	0
Smallpox	0	0	0
Measles	276	234	362
Chickenpox	79	43	46
Mumps	101	78	28
Infectious hepatitis	38	34	29
Typhus fever	1	0	1
Malaria	0	0	0
Cancer	953	624	703
Pellagra	0	0	0
Rheumatic fever	13	11	14
Rheumatic heart	30	34	24
Influenza	133	120	30
Pneumonia	326	292	164
Rabies—Human cases	0	0	0
Pos. animal heads	0	1	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

Current Morbidity Statistics

1965

	June	July	*E. E. July
Tuberculosis	121	142	162
Syphilis	334	189	135
Gonorrhea	433	368	323
Chancroid	0	3	2
Typhoid fever	1	2	2
Undulant fever	0	0	1
Amebic dysentery	2	1	3
Scarlet fever & strep. throat	138	183	37
Diphtheria	2	3	1
Whooping cough	13	10	21
Meningitis	8	3	4
Tularemia	0	0	0
Tetanus	1	2	2
Poliomyelitis	0	0	5
Encephalitis	0	0	1
Smallpox	0	0	0
Measles	234	32	92
Chickenpox	43	14	16
Mumps	78	40	22
Infectious hepatitis	34	32	53
Typhus fever	0	0	0
Malaria	0	0	0
Cancer	624	838	642
Pellagra	0	1	0
Rheumatic fever	11	8	14
Rheumatic heart	34	25	20
Influenza	120	46	19
Pneumonia	292	300	114
Rabies—Human cases	0	0	0
Pos. animal heads	1	4	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF VITAL STATISTICS

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA.

MAY, 1965

Ralph W. Roberts, M. S., Director

Live Births / Deaths / Causes of Death	Number Registered During May, 1965			Rates* (Annual Basis)		
	Total	White	Non-White	1965	1964	1963
Live Births	5,448	3,483	1,965	18.4	19.5	18.8
Deaths	2,661	1,723	938	9.0	9.1	8.7
Fetal Deaths	133	50	83	23.8	21.8	21.8
Infant Deaths—						
under one month	108	64	44	19.8	21.4	23.6
under one year	170	89	81	31.2	29.9	31.8
Maternal Deaths	1	1		1.8	8.7	9.1
Causes of Death						
Tuberculosis, 001-019	18	10	8	6.1	6.2	8.4
Syphilis, 020-029	4	2	2	1.4	1.0	1.4
Dysentery, 045-048	1		1	0.3	0.3	0.3
Diphtheria, 055						
Whooping cough, 056	1		1	0.3	0.3	
Meningococcal infections, 057	2	1	1	0.7	0.7	
Poliomyelitis, 080, 081						0.3
Measles, 085	2	1	1	0.7	0.7	0.3
Malignant neoplasms, 140-205	330	253	77	111.6	117.5	123.3
Diabetes mellitus, 260	44	30	14	14.9	17.3	11.9
Pellagra, 281						0.3
Vascular lesions of central nervous system, 330-334	383	230	153	129.6	116.5	122.9
Rheumatic fever, 400-402	2		2	0.7	0.7	0.7
Diseases of the heart, 410-443	890	591	299	301.1	314.1	299.6
Hypertension with heart disease, 440-443	129	54	75	43.6	45.1	40.9
Diseases of the arteries, 450-456	60	40	20	20.3	22.5	18.9
Influenza, 480-483	2		2	0.7	1.4	2.8
Pneumonia, all forms, 490-493	90	58	32	30.4	20.8	17.1
Bronchitis, 500-502	3	2	1	1.0	2.1	1.4
Appendicitis, 550-553	3	3		1.0	0.3	0.7
Intestinal obstruction and hernia, 560, 561, 570	15	11	4	5.1	3.8	4.5
Gastro-enteritis and colitis, under 2, 571.0, 764	7	1	6	2.4	1.0	1.4
Cirrhosis of liver, 581	17	13	4	5.8	4.8	3.1
Diseases of pregnancy and childbirth, 640-689	1	1		1.8	8.7	9.1
Congenital malformations, 750-759	22	15	7	4.0	7.5	4.8
Immaturity at birth, 774-776	30	16	14	5.5	6.9	8.0
Accidents, total, 800-962	199	143	56	67.3	70.4	58.7
Motor vehicle accidents, 810-835, 960	107	73	34	36.2	34.0	26.9
All other defined causes	385	246	139	130.2	122.0	126.8
Ill-defined and unknown causes, 780-793, 795	150	56	94	50.7	52.0	43.0

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

BUREAU OF VITAL STATISTICS

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA.

JUNE, 1965

Ralph W. Roberts, M. S., Director

Live Births / Deaths / Causes of Death	Number Registered During June, 1965			Rates* (Annual Basis)		
	Total	White	Non-White	1965	1964	1963
Live Births	5,386	3,544	1,842	18.8	20.7	20.4
Deaths	2,398	1,569	829	8.4	9.4	8.7
Fetal Deaths	112	42	70	20.4	24.2	21.0
Infant Deaths—						
under one month	95	47	48	17.6	19.4	24.8
under one year	128	58	70	23.8	25.4	33.3
Maternal Deaths	3	1	2	5.5	6.8	8.7
Causes of Death						
Tuberculosis, 001-019	13	7	6	4.5	7.5	6.5
Syphilis, 020-029	2	2		0.7	1.4	1.1
Dysentery, 045-048						0.4
Diphtheria, 055						
Whooping cough, 056						
Meningococcal infections, 057	2	1	1	0.7	0.7	
Poliomyelitis, 080, 081					0.4	0.4
Measles, 085					1.8	0.4
Malignant neoplasms, 140-205	339	243	96	118.5	124.3	117.6
Diabetes mellitus, 260	39	25	14	13.6	11.5	13.0
Pellagra, 281						
Vascular lesions of central nervous system, 330-334	339	215	124	118.5	148.0	122.7
Rheumatic fever, 400-402						1.4
Diseases of the heart, 410-443	738	532	206	258.0	320.0	295.5
Hypertension with heart disease, 440-443	96	39	57	33.6	44.1	48.7
Diseases of the arteries, 450-456	66	41	25	23.1	21.5	18.8
Influenza, 480-483	1	1		0.3	0.7	2.2
Pneumonia, all forms, 490-493	48	29	19	16.8	19.3	23.1
Bronchitis, 500-502	4	4		1.4	1.1	1.4
Appendicitis, 550-553	1	1		0.3	1.1	1.1
Intestinal obstruction and hernia, 560, 561, 570	13	12	1	4.5	6.1	3.2
Gastro-enteritis and colitis, under 2, 571.0, 764	9	2	7	3.1	1.1	2.5
Cirrhosis of liver, 581	19	11	8	6.6	5.0	6.5
Diseases of pregnancy and childbirth, 640-689	3	1	2	5.5	6.8	8.7
Congenital malformations, 750-759	22	17	5	4.1	3.8	5.5
Immaturity at birth, 774-776	26	10	16	4.8	5.2	8.7
Accidents, total, 800-962	204	148	56	71.3	65.2	57.0
Motor vehicle accidents, 810-835, 960	104	80	24	36.4	33.0	29.2
All other defined causes	351	212	139	122.7	134.7	131.0
Ill-defined and unknown causes, 780-793, 795	159	55	104	55.6	45.5	38.2

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

a rapid lift from the hell of depression



Doré Illustration
from
Dante's Inferno

often relieves mental pain in 2-5 days

NORPRAMIN®
(desipramine hydrochloride)

Norpramin is a rapid-acting specific drug for the treatment of depression. Depressive signs and symptoms—sometimes described as "mental pain"—typically begin to improve in 2-5 days. Patients are more hopeful, less empty and less weighed down by their troubles. Norpramin has only slight sedative qualities, nevertheless anxiety *secondary to depression* is frequently relieved as depression is lifted. If anxiety or tension persists it can be controlled by adding a tranquilizer or by reducing dosage. Norpramin is not a MAO inhibitor. Side effects are usually mild.

DOSAGE AND ADMINISTRATION

Optimal results are obtained at a dosage of about 150 mg./day—two 25 mg. tablets t.i.d. After achieving optimal results, a maintenance dose (50-100 mg./day) should be sought.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

IN BRIEF:

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

Contraindications and Precautions: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established.

Adverse Effects: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

Supplied: Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

because the immaturity of infants
and children influences their response to
disease and drugs*...

Pediamycin™

erythromycin ethyl succinate, Ross

an oral antibiotic
especially suited in forms
especially prepared
for infants and children...

clinically effective
and exceptionally safe



Indications: Common infections of the ear, nose, throat, respiratory tract (including bronchitis and pneumonia) and other sites, due to susceptible organisms: streptococci, pneumococci, most strains of staphylococci and Hemophilus influenzae.

Supply: For children: **Pediamycin Chewable** tablet: scored, cherry-flavored, 200 mg erythromycin activity. For small children and infants: **Pediamycin Suspension:** granules for oral suspension, 60 ml bottles, 200 mg erythromycin activity per teaspoonful (5 ml); full and half teaspoon measure in package. **Pediamycin Drops:** granules for oral suspension, 30 ml bottles, 100 mg erythromycin activity per dropperful (2.5 ml); calibrated dropper in package.

Dosage: For infants and young children, 15 mg to 25 mg per pound of body weight per day in four to six divided doses. For larger children, the adult dosage scale of 1 to 2 grams per day.

Contraindication: Pediamycin is contraindicated for patients with known sensitivity to erythromycin.

Precautions: Side effects are relatively rare. Should a patient show signs of hypersensitivity, appropriate countermeasures (e.g., administration of epinephrine, steroids, etc.) should be employed and the drug withdrawn.

TM—Trademark

*Done, A. K., in Drugs of Choice 1964-1965, Modell, W., ed., St. Louis, The C. V. Mosby Co., 1964, p. 66.

ROSS LABORATORIES COLUMBUS, OHIO 43216

serving physicians who attend the needs of children from birth through adolescence

The discomforts of

DIARRHEA
MUCOUS COLITIS
DIVERTICULITIS
SPASTIC URETERITIS
BLADDER SPASM

. . . are relieved by direct musculotropic action with

Trocinate®

BRAND THIPHENAMIL HCl

Available in 100 milligram pink sugar-coated tablets.

The high therapeutic index permits dosage sufficient to relieve spasm promptly. The usual initial dose is 4 tablets. Maintenance dosage is usually one or two tablets 4 times a day.

Trocinate *BRAND* THIPHENAMIL HCl

BETA-DIETHYLAMINOETHYL DIPHENYLTHIOACETATE HYDROCHLORIDE

. . . directly relaxes smooth muscle spasm
. . . combats hypermotility
. . . non-mydriatic – may be used in glaucoma

Trocinate (Thiphenamil HCl) has been found in three clinical studies, (J. Mo. Med. Assoc., 48:685-6; Med. Rec. & Annals, 43:1104-6; J. Urol., 73:487-93), to be effective and to be free of side-effects. Fifteen years of wide clinical usage has affirmed the safety and effectiveness of Trocinate.

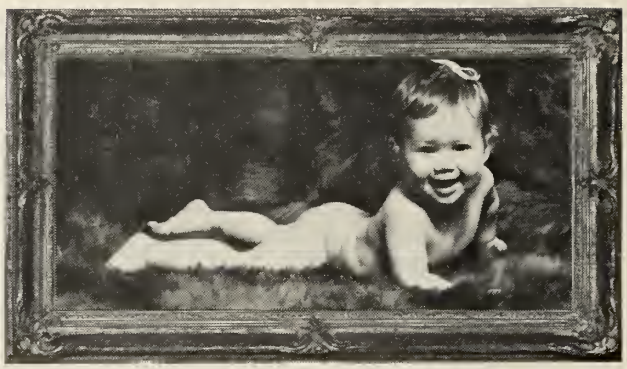
WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

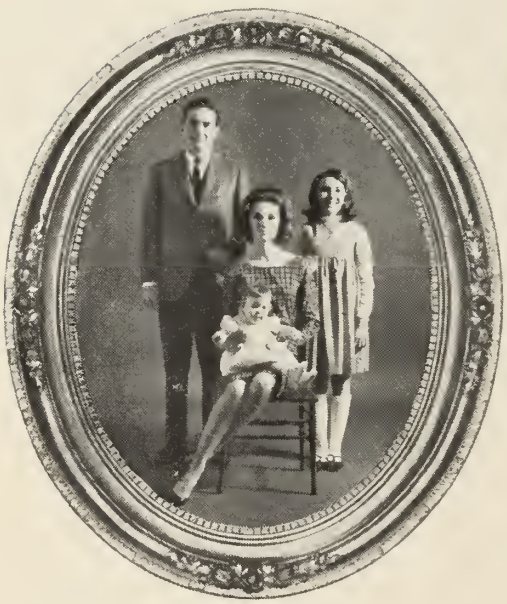
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Turn a bundle of colic



into a bundle of joy





COLIC, often in part a reflection of family tension, adds sleepless nights to patients' and parents' distraught days. Pediatric Piptal with Phenobarbital slows down spasm, diminishes pain and crying, improves feeding patterns . . . permits sleep and rest . . . for patient and family.

Pleasant tasting Pediatric Piptal with Phenobarbital is miscible in milk, formulas and fruit juices, and may also be administered by dropper directly on the infant's tongue. Dosage is 0.5 cc. 15 minutes before feeding; in severe cases, 1.0 cc. four times daily. High doses may occasionally cause constipation with tenesmus and, rarely, flushing without fever. Contraindicated in bowel obstruction or sensitivity to phenobarbital or anticholinergics. Available in 30 cc. dropper bottles, droppers calibrated to deliver 0.5 cc.

PEDIATRIC PIPTAL® WITH PHENOBARBITAL

each cc. contains: 6 mg. phenobarbital (warning: may be habit forming); 4 mg. Piptal® (pipenzolate bromide), and 20% alcohol in a pleasant-tasting solution.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201



Prompt relief of pain and spasm in functional g.i. distress...



PIPTAL® (pipenzolate bromide) efficiently suppresses acid secretion and motility ... relieves pain and spasm of peptic ulcer. Despite its potent gastrointestinal effects, "its clinically effective therapeutic dose is well below that required to produce side reactions."[1] Because urinary retention is rarely a problem, PIPTAL (pipenzolate bromide) is "a highly desirable drug in the treatment of peptic ulcer in older patients ..."[2] Tolerance to PIPTAL (pipenzolate bromide) has not been demonstrated, and the drug may be administered over prolonged periods without loss of efficacy. *PIPTAL-PHB is specifically designed for the tense ulcer patient who will benefit from the sedative effect of phenobarbital.*

1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. *8*:73-77 (Jan.) 1957

2—Asher, L.M.: Am. J. Digestive Diseases *4*:272 (Apr.) 1959

PIPTAL®
(pipenzolate bromide)

PIPTAL®-PHB
(phenobarbital, 16 mg., pipenzolate bromide, 5 mg.)

IN BRIEF: PIPTAL—Each tablet contains 5 mg. pipenzolate bromide, PIPTAL-PHB—Each tablet (or 5 cc. of elixir) contains phenobarbital (warning: may be habit forming) 16.0 mg., Piptal (pipenzolate bromide) 5 mg. The elixir contains alcohol 20%.

Side Effects: Dry mouth, blurring of vision or drowsiness may occur.

Contraindications: Withhold in glaucoma, bladder or g.i. obstruction, cardiac arrhythmias and in sensitivity to anticholinergics or phenobarbital (Piptal-PHB). Caution should be observed in patients with prostatic hypertrophy.

Administration and Dosage: PIPTAL or PIPTAL-PHB Tablets: One tablet three times a day before meals and one or two tablets at bedtime. (PIPTAL-PHB Elixir: One teaspoonful three or four times daily for adults and children over six years of age.)

Supplied: PIPTAL (pipenzolate bromide) 5.0 mg. Tablets—bottles of 100. PIPTAL-PHB Tablets—bottles of 100. PIPTAL-PHB Elixir—bottles of 8 fluid ounces.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

On the Political Scene at the Capitol in Montgomery, Alabama



Representative Sim A. Thomas, Eufaula.

Committee on Finance and Taxation, Charles (Pete) Mathews, Chairman.





The hard-working Committee on Public Relations and Economics met on Sunday, July 11. Eating lunch in the top picture, left to right, are Drs. L. D. McLaughlin, Ozark; Ira L. Myers, Montgomery; T. Riley Lumpkin, Enterprise; Carl A. Grote, Jr., Huntsville; and Mr. W. V. Wallace, executive secretary. The same group is shown in the lower picture.



"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.



a working analgesic for the working arthritic



Arthralgen® rapidly relieves early morning stiffness and arthritic pain. It promises a quicker response in most patients because its analgesic ingredients need no metabolic conversion before they act. Combining two better-tolerated, time-tested analgesics, acetaminophen and salicylamide, into a pharmacologically sound and therapeutically effective formulation, Arthralgen relieves pain rapidly with less likelihood of gastric irritation than aspirin.

in maintenance therapy . . .

Because it contains no sodium, Arthralgen is often a safer and more suitable analgesic for use in the long-term treatments of arthritic patients who have other conditions which require sodium restriction.[1]

Arthralgen®

Each tablet contains:

Salicylamide	250 mg.
Acetaminophen	250 mg.
Ascorbic acid (Vitamin C)	25 mg.

Arthralgen®-PR

(Arthralgen with prednisone 1 mg.)

BRIEF SUMMARY:

Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acute gouty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chickenpox or susceptible persons exposed to it.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

SIDE EFFECTS: Nausea, GI upset, or mild salicylism may rately occur. Symptoms of hypercorticoidism dictate reduction of dosage of Arthralgen-PR.

DOSAGE: One or two tablets four times a day. After remission of symptoms dosage should be reduced to the minimum maintenance level.

REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953.

A. H. ROBINS COMPANY, INCORPORATED RICHMOND, VIRGINIA



Fifth Annual Meeting of the Alabama Chapter, American Academy of General Practice held in Birmingham on July 21-23, 1965.

(Above) Dr. H. C. Mullins, Fairhope, President, Dr. Lester A. Brown, Atlanta, Dr. W. C. Browne, Vincent.

(Below) One of the groups participating in the discussions held on the Morning of Psychiatry.

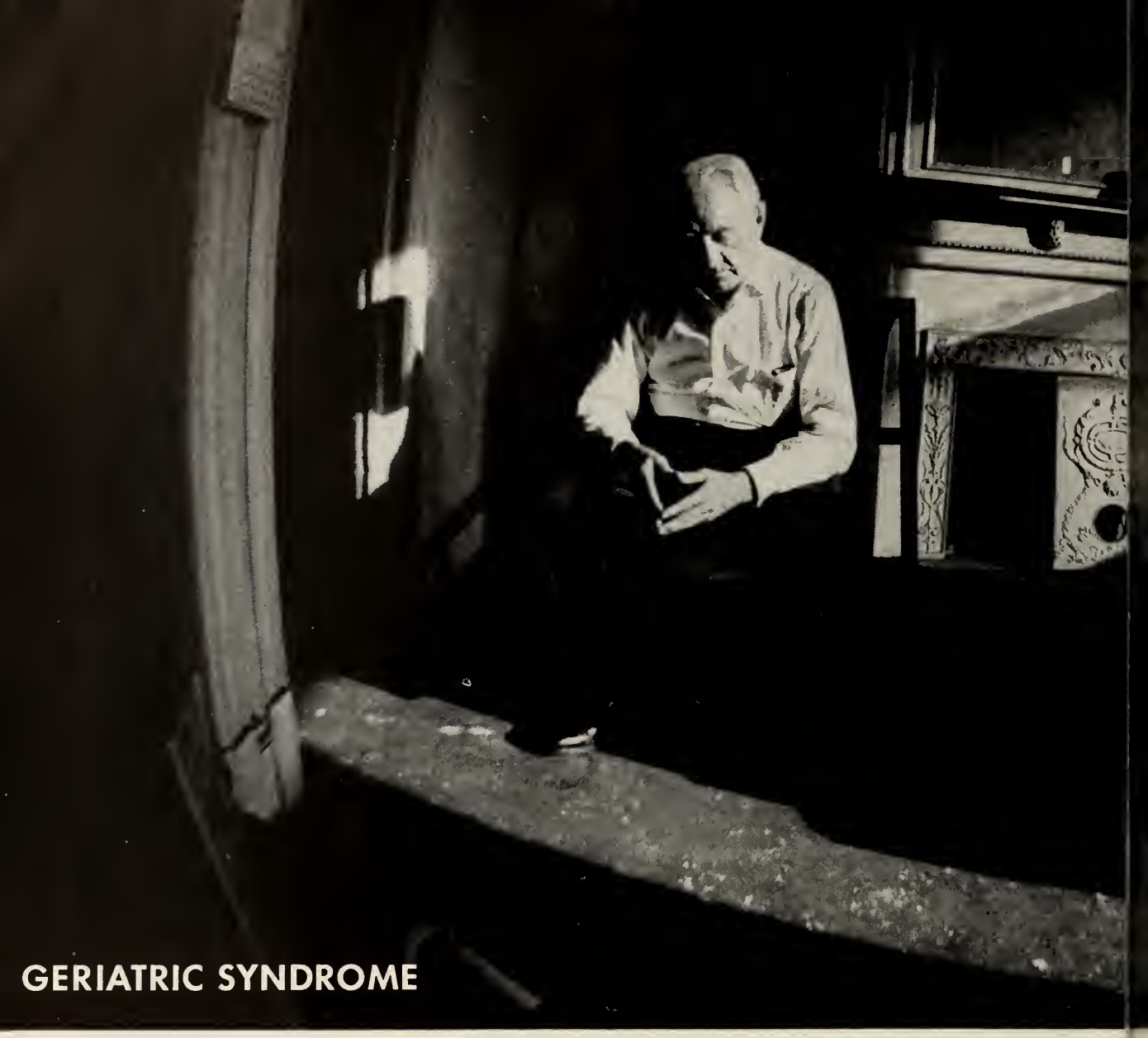
(Right) Scenes at the Vestavia Country Club Seafood Buffet given by Marion Laboratories.











GERIATRIC SYNDROME

when a change in environment overwhelms him with anxiety

Failing health, financial difficulties, or the death of a spouse are among the reasons why elderly people may be obliged to leave their familiar surroundings. Moving in with children or entering a home for the aged may satisfy practical requirements but can be psychologically traumatic since emotional resilience tends to diminish with age.

Even when anxiety reaches overwhelming proportions, you can counteract it promptly with the potent tranquilizer—Atarax (hydroxyzine HCl).

The outstanding systemic safety record of Atarax makes it particularly suitable for geriatric patients whose drug tolerance is often low. The usual initial dosage in such patients is 50 mg. q.i.d. However, this tranquilizer is so well tolerated that dosage can be adjusted to meet individual requirements. The wide variety of dosage forms allows flexibility of administration from any standpoint—convenience, patient preference, or emergency requirements.

No age, of course, is exempt from anxiety and any number of circumstances can unleash it. Keep Atarax in mind for *all* your emotionally distressed patients—from under 6 to over 60.

for any age—for any stage of anxiety

Rx **ATARAX**® Roerig

(hydroxyzine HCl) tablets syrup parenteral

...In any condition where tissue depletion of the water-soluble vitamins is found, Rx **RoeriBeC**® therapeutic complex with 500 mg. of vitamin C.

Roerig

J. B. Roerig and Company
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being®
New York, New York 10017



Side effects and precautians: The transitary drowsiness which may accur with hydraxyzine HCl usually disappears spontaneously in a few days with cantinued therapy, ar is carrectable by dosage reductian. Dryness of the mauth may be seen with higher dases. Involuntary matar activity has been reported in haspitalized patients an higher than recommended dases. Hydroxyzine HCl may potentiate CNS depressants, narcatics such as meperidine, barbiturates, and anticoagulants. In conjunctive use, dosage for these drugs shauld be decreased. Because drowsiness may occur, patients shauld be cautianed against driving a car ar operating dangerous machinery. **Parenteral Salutian Precautians and cantraindications:** This dosage farm is intended only for I.M. or I.V. administratian and shauld not, under any circumstances, be injected subcutaneously ar intraarterially. When the usual precautians for I.M. injection have been followed, reparts of saft tissue reactians have been rare. I.V. administratian should be slow, na faster than 25 mg. per minute, and shauld nat exceed 100 mg. in any single dase. Particular care shauld be used ta insure injectian anly inta intact veins; a few instances af digital gangrene accurring distal ta the injectian site have been attributed ta inadvertent intraarterial injectian ar periarterial extravasatian, bath of which shauld be avaided. **More detailed prafessianal information available on request.**

PERSONALS

Dr. John Curran Sullivan, an Otolaryngologist from Dallas, Texas, moved to Montgomery recently to be associated with Dr. Bruce Holding, Jr. Dr. Sullivan is a native of Hattiesburg, Mississippi, and is a graduate of University of Mississippi Medical Center, having received his M. D. degree in 1960. He has completed residency training at the Texas Children's Hospital, Western Medical School, and was chief resident at Dallas Veterans Administration Hospital. Dr. and Mrs. Sullivan have three children and they reside at 3012 North Colonial Drive in Montgomery.

* * *

Dr. William O. Owings, a native of Brent, Alabama, has opened his practice of general surgery in his home town. Dr. Owings received his B. S. Degree from the University of Alabama, M. D. Degree from Tulane University of Louisiana. He spent two years in the U. S. Army, serving in the Surgical Service at Mobile Army Hospital, Ft. McClellan, Alabama. Dr. Owings' office will be located in the Owings Clinic Building, Brent, Alabama. He is on the staffs of the Bibb County Hospital and the Druid City Hospital in Tuscaloosa, Alabama.

* * *

Dr. Cary G. Hodnett, Alexander City, has announced the opening of his office for the practice of medicine. He graduated from Auburn University in 1958 and from the University of Alabama Medical College in 1962. Dr. Hodnett served in the United States Navy and holds the rank of Lieutenant in the reserves.

* * *

Dr. R. Craig Wesson, a native of Lanett, Alabama, has joined Dr. Franklin E. Mercer at the Heflin Clinic. Dr. Wesson is a graduate of the University of Alabama Medical School. For the past two years he has served in the U. S. Army Medical Corps in Nuremburg, Germany.



**Happily,
not all your patients
are overweight**



**but
for those who are...**

Bamadex®

d-amphetamine sulfate (15 mg.) and meprobamate (300 mg.)

Sequels®

Sustained Release Capsules

Most overweight patients could benefit from the appetite control provided by the prolonged anorexigenic-tranquilizing action of BAMADEX SEQUELS: anorexigenic action through the central stimulant effect of the amphetamine; tranquilizing action with only mild sedation through meprobamate; prolonged action through sustained release of active ingredients.

Contraindications: Hyperexcitable and prepsychotic states; patients hypersensitive to meprobamate.

Side Effects: Occasional allergic skin reactions may occur with meprobamate, accompanied by fever, nonthrombocytopenic purpura, angioneurotic edema, hypotension, or bronchial spasm. Drowsiness with or without ataxia and/or alteration in visual accommodation may occur. Effects of alcoholic beverages may be increased by meprobamate. Use with caution in patients with coronary or cardiovascular disease or severe hypertension. Prolonged use may result in dependence. Reactions can occur if drug is not withdrawn gradually.

LEDERLE LABORATORIES • A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y. Lederle

6205



MISS CYNTHIA SANSING SMITH

Miss Cynthia Sansing Smith, student at Auburn University, has been working at the Central Office for the past three summers. She will be a junior this fall and is majoring in English, minoring in Journalism.



MRS. ELOISE PHILLIPS

Newest addition to the Central Office Staff is Mrs. Eloise Phillips. Mrs. Phillips, an attractive brunette, has lived in Montgomery for 14 years. She has one son, Christopher Henry, four years old.



for psychiatric treatment

Peachtree Hospital, located in Atlanta, Georgia, is a complete psychiatric, alcoholic and drug addiction treatment facility accredited by the Joint Commission on Accreditation of Hospitals ☐ The hospital has 65 beds, 47 of which are devoted to the care of psychiatric patients and 18 of which, in a separate area, are for patients with acute cases of chronic alcoholism or drug addiction ☐ Treatment procedures include psychotherapy, electroconvulsive shock therapy, subinsulin coma and chemotherapy ☐ *We will be pleased to provide further information upon request.*

ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

peachtree hospital

41 PEACHTREE PLACE, N. E. / TELEPHONE 873-5681 / ATLANTA 9, GEORGIA



FOR YOUR ELDERLY ARTHRITIC PATIENTS...

an effective
GERIATRIC
antiarthritic
with
REASSURING SAFETY FACTORS

Effectiveness, dependability and reassuring Safety Factors make PABALATE-SF a logical choice for antiarthritic therapy in elderly patients—even when osteoporosis, hypertension, edema, peptic ulcer, cardiac damage, latent chronic infection and other common geriatric conditions are present. The potassium salts of PABALATE-SF cannot contribute to sodium retention...the enteric coating assures gastric tolerance...and clinical experience shows that this preparation does not precipitate the serious reactions often associated with corticosteroids or pyrazolone derivatives.

Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

Also available: PABALATE—when sodium salts are permissible. PABALATE-HC—Pabalate-SF with hydrocortisone.

Pabalate®-SF

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

—the new, convenient way to prescribe
PABALATE-SODIUM FREE

The ladies enjoyed a luncheon and program at "The Club." Mrs. L. A. Reich, far right, is shown presenting an arrangement of flowers to the president of the Mother Singers. The Gold Room was the setting for the afternoon's entertainment.





More Pictures of the Seafood Buffet at Vestavia Country Club



Mrs. M. C. Dunn, Dr. Dunn, Dr. G. E. Rudd, and Dr. C. J. Fisher.



Dr. H. C. Mullins, Mrs. W. J. B. Owings, Dr. Owings, and Mrs. Mullins.

OBITUARY

CLARK, JEAN—Jean Clark, M. D. (Mrs. W. C. Browne), died unexpectedly at her home in Vincent, Alabama, on July 29, 1965. Born in Neola, Iowa, Dr. Clark received her M. D. degree from the University of Nebraska, and interned at Charity Hospital in New Orleans, Louisiana. She was the first woman in medicine to be granted a residency in obstetrics and gynecology on the Tulane Service.

Dr. Clark was the first woman to be elected to the Board of Trustees of the Medical Association of the State of Alabama. She was secretary-treasurer and past president of the Shelby County Medical Society, member of the Medical Association of the State of Alabama, American Medical Association, Alabama Academy of General Practice, and American Academy of General Practice.

She was on the staff of the Shelby County Memorial Hospital in Alabaster, Alabama.

Dr. Clark was aptly described as a compassionate person, and will be greatly missed by her colleagues and friends throughout the state.



DR. JEAN CLARK

Survivors include her husband, Dr. W. C. Browne, Vincent; two sons, William Craig Browne, Jr., and Clark Browne; one daughter, Miss Marjorie Browne, Birmingham; father, Mr. Vern Clark of Neola, Iowa; five sisters, Mrs. Mae Pittman of Tampa, Florida; Mrs. Effie Meckes of Florence; Mrs. Edna Anderson of Chula Vista, California; Mrs. Florine Hay of Dallas, Texas; and Miss Connie Clark of St. Paul, Minnesota; three brothers, Victor Clark of Tempe, Arizona; Vance Clark of Chapel, Nebraska, and Cecil Clark of Florrisant, Missouri; and one grandson.



Drs. George E. Rudd, Pinson, and W. C. Browne, Vincent, discuss progress of the meeting.



Dr. Beverly T. Mead, Omaha, Nebraska, and Dr. William C. Ruffin, Gainesville, Florida, talk about their subject "How to Get Rid of Your Crocks."

:utazolidin®

ınd of
lenylbutazone

ll
:steoarthritis



ierapeutic effects

number of investigators report improvent in about 75% of cases. Relief of pain d stiffness is the predominant response. equently, there is also a significant provement in function. The beneficial ects of the drug are usually seen by the rd or fourth day of treatment.

ere is general agreement that milder ses of osteoarthritis are preferably ated by simple analgesics. In many tients, however, this mode of therapy ls to give sufficient relief. Because ster-ds are not very effective in this form of thritis, phenylbutazone affords the drug erapy most capable of relieving the more vere cases. For best results, it is recommended that treatment with phenylbutazone combined with physiotherapy and other propriate supportive measures.

osage

ne initial daily dosage in adults is 300-600 g. in divided daily doses. In most instances, 00 mg. daily is sufficient for maximum ierapeutic response. A trial period of one eek is adequate to determine the effects the drug; if there is no improvement, iscontinue the drug. When improvement oes occur, dosage should be promptly ecreased to the minimum effective level: his should not exceed 400 mg. daily, and is ften achieved with only 100-200 mg. daily.

Precautions

Before prescribing, the physician should btain a detailed history and perform a omplete physical and laboratory examinaon, including a blood count. The patient hould be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning: If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Side effects

The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Contraindications

These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient cannof be seen regularly, when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin® alka are contraindicated in patients with glaucoma.

Note: The physician should be fully aware of dosage, precautions, side effects and contraindications as contained in the complete prescribing information.

Butazolidin alka

Each capsule contains:	
Butazolidin, brand of phenylbutazone	100 mg.
dried aluminum hydroxide gel	100 mg.
magnesium trisilicate	150 mg.
homatropine methylbromide	1.25 mg.

Butazolidin

brand of phenylbutazone
Tablets of 100 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York
BU-3143



Another group discussion at the Morning of Psychiatry.



Dr. Carroll L. Witten, President-elect, American Academy of General Practice; Dr. Floris M. Herbert, Montgomery; and Dr. J. Michaelson, Foley, Past President, American Academy of General Practice, at the Annual Banquet, Parliament House in Birmingham.

to help relieve pain in common anorectal disorders

"non-caine" Diothane®

Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form...both are now available.

DIOTHANE OINTMENT

COMPOSITION:
diperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:
Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.





DIOTHANE SUPPOSITORIES

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215/Weston, Ontario

August 10, 1965

TO: Delegates
Alternate Delegates
Presidents and Presidents-Elect,
State Medical Associations
Editors, State Medical Associations
Secretaries, Metropolitan Medical
Societies

The following TWX was sent today to the headquarters offices of the state medical associations:

"AMA Board of Trustees held special session on August 7-8, Chicago, to discuss Public Law 89-97 (Social Security Amendments of 1965) and related matters. Information re this meeting is being disseminated by TWX or special delivery air mail to state medical association presidents and presidents-elect, headquarters of state medical associations and metropolitan medical societies, members of the AMA House of Delegates, and state medical association editors.

"Since the medicare bill has become Public Law 89-97, the Board of Trustees feels that its role should be to give advice and guidance to the Secretary of Health, Education, and Welfare to the end that programs developed and regulations promulgated will provide the stated benefits in the most meaningful manner to our patients with a minimum of disturbance and inconvenience to the medical profession.

"The Board has appointed the following Advisory Committee to represent AMA in discussions re this law with Secretary of HEW and his staff: President James Z. Appel, Chairman; President-Elect Charles L. Hudson; Secretary-Treasurer Raymond M. McKeown, Trustee Dwight L. Wilbur, and Chairman of Council on Medical Service Russell B. Roth. The Office of the Executive Vice President will staff this Committee.

"This Committee holds organizational meeting Friday, August 13. Presumably subcommittees will be appointed in special areas. This Committee will consult with HEW officials regarding implementation of law and regulations to be promulgated. Its recommendations will be reported regularly to Board of Trustees and through Board to the House of Delegates and other appropriate groups.

"Board considered action of House of Delegates in June: 'Resolved, That when the fate of the pending medicare legislation is determined, this House will review, in special session if necessary, the effect of the law and take whatever action is deemed necessary;' and after careful review of current situation took no action to convene special session in view of imminence of November session in Philadelphia when much more information regarding regulations and related subjects will be available.

"As reported in earlier TWX, pursuant to House of Delegates directive regarding restatement of offer to meet with President, Task Force of Board of Trustees met with President Johnson on July 29 and subsequently with Secretary Celebrezze and HEW officials. The President and HEW asked AMA to participate in formulation of regulations and assured AMA Task Force that no regulations would be finalized without full AMA opportunity to evaluate and recommend changes.

"The following is a summary of the items discussed by legal counsel at the meeting of the Board of Trustees on August 8, 1965:

"1. Physicians acting alone or as a group through their medical organizations may freely criticize Public Law 89-97 and may seek its repeal or modification.

"2. An individual physician acting independently and not in concert with others can lawfully refuse to accept any person as a patient who is a beneficiary under the program.

"3. The physician's right to practice in a hospital is not vested; he is obligated to abide by the reasonable rules and regulations imposed by the hospital administration. Such rules and regulations may directly or indirectly require the cooperation of the physician in assisting the hospital to participate as a provider of services under the law.

"4. Although Public Law 89-97 provides that nothing in this law 'shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided,' other laws, such as the Sherman Antitrust Act, may apply to certain situations involving group action.

"5. The basic principle of antitrust laws is to prohibit private restraints which operate to impede a competitive economy; and action by an organized group of individuals in refusing to deal with others has been held illegal. When such restraints adversely affect those engaged in providing health services, such as hospitals, nursing homes and carriers, relief may be provided by law. The Sherman Antitrust Act delegates to the courts broad powers to interpret and apply the prohibitions of the law, case by case, in civil and criminal actions brought by the Department of Justice and by private persons.

"6. Conspiracy under the antitrust laws may emanate from a common understanding or an express or implied agreement. In a number of cases involving medical organizations, statements of policy by the organization, such as resolutions and 'ethical' rules of conduct, have been interpreted as evidence of conspiracy under the particular facts and circumstances.

"7. If physicians acting in concert through medical organizations refuse to participate in the program, such action would involve exposure to the application of the Sherman Antitrust Act.

"The Board of Trustees will present thoroughly documented and extensive report to House of Delegates at its regular session in Philadelphia discussing all aspects of the new law as it affects the profession, legal questions involved in participation and non-participation, relationship of the carriers to government and to the profession, the effect of the law on pathologists, radiologists, and other specialty groups, and the important new provisions in the Kerr-Mills medical assistance program.

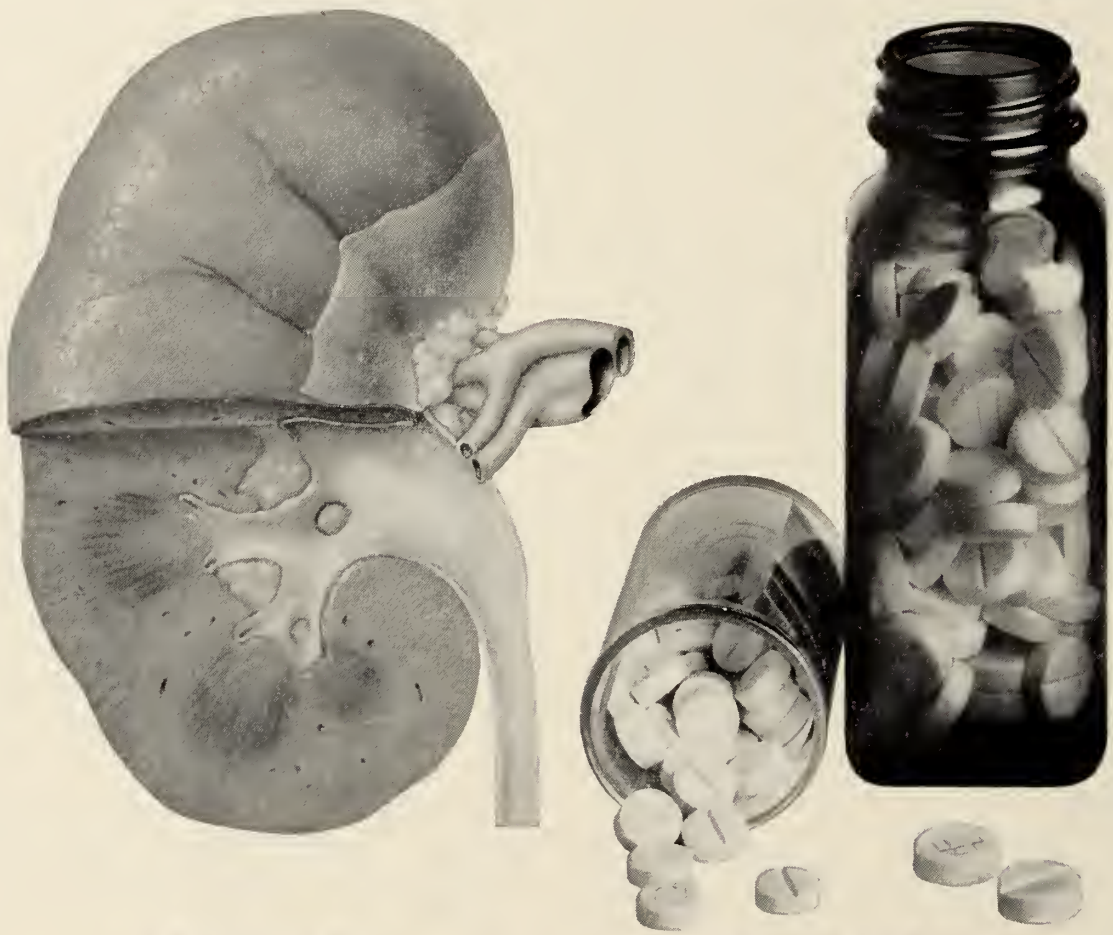
"The Board will spare no effort to keep you completely informed of developments as they occur. Every channel of communication available will be utilized as indicated.

"Meanwhile, the Board urges all physicians and especially leaders of state and county medical societies to face the problems ahead with restraint, a clear mind, and unity."

Sincerely,

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Announce

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FRIDAY, SEPTEMBER 17, 1965

THE EDGEWATER GULF HOTEL, EDGEWATER PARK, MISSISSIPPI

This Symposium is made possible by a grant from and with the cooperation of Lederle Laboratories

MORNING SESSION

Convention Hall No. 1

9:00 — **Registration—All Day**

Moderator:

Herschel P. Bentley, Jr., M. D., F. A. A. P.
Professor and Chairman, Department of Pediatrics, Medical College of Alabama, Birmingham

9:50 — **Welcome and Opening Remarks: Edward A. Harris, M. D., F. A. A. P., State Chairman for Alabama**

10:00-10:40 — **The Subtly Starving Child**

Alex F. Robertson, M. D.
Assistant Professor, Department of Pediatrics; Director of Newborn Services, The Ohio State University Hospital, Columbus

10:40-11:20 — **Congenital Defects—What Price Salvage?**

James G. Hughes, M. D., F. A. A. P.
President-Elect, American Academy of Pediatrics;
Professor of Pediatrics, University of Tennessee College of Medicine, Memphis

11:20-12:00 — **A Practical Investigation of Inborn Errors of Metabolism**

Vincent C. Kelley, M. D., F. A. A. P.
Professor of Pediatrics, University of Washington School of Medicine, Seattle

12:00-12:30 — **Questions and Panel Discussion**

12:45-2:15 — **Luncheon for physicians and wives Convention Hall No. 2**

Chairman

Max R. Woodward, M. D., F. A. A. P.
Chairman, District VII, Sherman

Speaker

"The Three R's of Adolescence"

Bernice C. Sachs, M. D.
President, American Medical Women's Association;
Psychosomatic Medicine, Group Health Clinic and Hospital, Seattle

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AFTERNOON SESSION

Convention Hall No. 1

Moderator:

William A. Daniel, Jr., M. D., F. A. A. P.

Past Chairman, Alabama Chapter of the American Academy of Pediatrics, Montgomery

2:30-3:10 — **The Child Who Fails to Thrive Socially**

Clifford Grulee, Jr., M. D., F. A. A. P

Dean and Professor of Pediatrics, University of Cincinnati College of Medicine, Cincinnati

3:10-3:50 — **Psychological or Emotional Aspects**

Bernice C. Sachs, M. D.

3:50-4:05 — **Recess**

4:05-4:45 — **Failure to Thrive Due to Neurological and Ophthalmological Problems**

J. Lawton Smith, M. D.

Associate Professor of Ophthalmology, Assistant Professor of Neurology, University of Miami School of Medicine, Coral Gables, Florida

4:45-5:15 — **Questions and Panel Discussion**

5:30 — **Business Session, Alabama Chapter of the American Academy of Pediatrics**

5:30-6:30 — **Reception—Convention Hall No. 2**

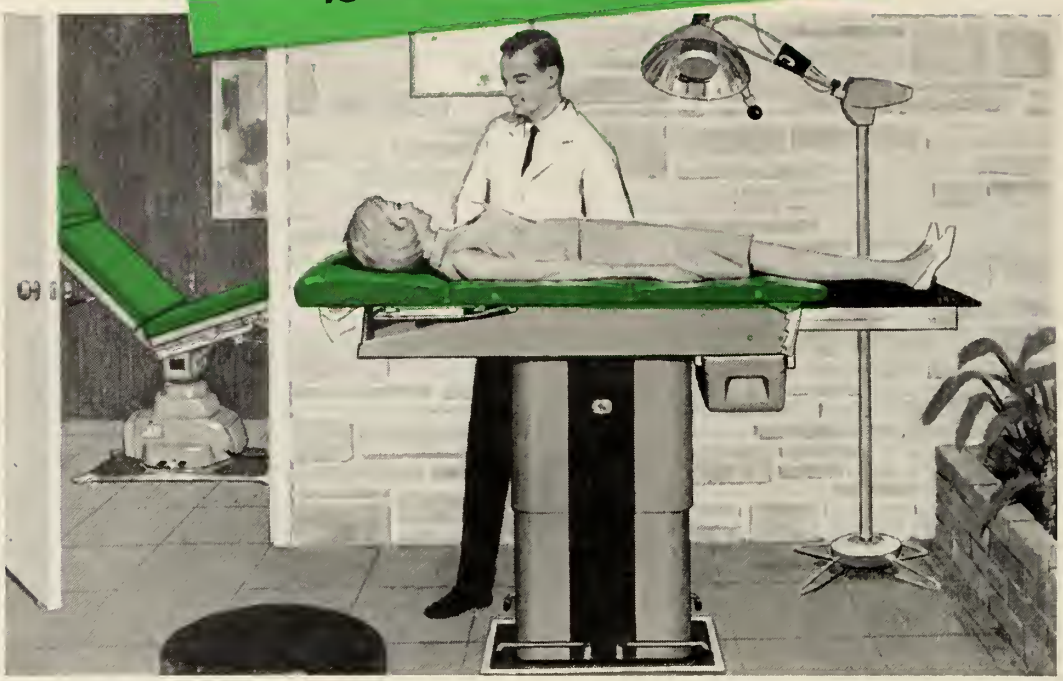
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Wives please contact: Mrs. W. Steve Sekul
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The Woman's Auxiliary



We are very pleased to have as our advisors this year, appointed by Dr. James G. Donald, to the AUXILIARY from the Medical Association the following: Dr. William L. Smith, Montgomery, Chairman; Dr. James K. V. Willson, Mobile; Dr. William G. Thuss, Sr., Birmingham; Dr. William D. Anderson, Tuscaloosa; Dr. L. H. Clemmons, Cullman. The advice of this splendid committee will be felt throughout the State concerning our projects. We have already had the approval of our support in the legislative campaign to procure additional funds for the State Department of Health.

Mrs. James K. V. Willson, State Legislation Chairman, wrote letters to all the County Auxiliaries requesting that a resolution be sent to their respective State Senators. A resolution was mailed by your president to her State Senator Larry Dumas and I would like for each of you to know his reply which is as follows:

> "Thanks for sending me the resolution of the Woman's Auxiliary asking help and support for H. B. 874 to increase the tax on cigarettes in order to enable the State to increase its appropriations to the State Department of Public Health. Your resolution ably sets forth the reasons for increasing this appropriation. I am most sympathetic with our State Department of Health, which is doing an excellent job with very limited funds. I am hopeful that we can provide the additional funds to enable the State Department to perform the services so vital to the protection of the health of the citizens of this State."

The Advisors have approved our support of the Rural Health Council of Alabama. Our Auxiliary is represented on this council by the following members: Mrs. W. R. Sutton, Blountsville; Mrs. Lowell H. Clemmons, Cullman; Mrs. J. P. Brooke, Bessemer; Mrs. William A. Cunningham, Birmingham; Mrs. John D. Rayfield, Sylacauga, who is State Rural Health Chairman; and your president. This council is also helping the Department of Public Health whose representative is Mr. Ray Overton and several others. Our Auxiliary has offered volunteers for the work of Preventive Medicine and the Immunization Project.

We are looking forward to our Fall Conference in September at the Guest House Motel in Birmingham on the 16th and 17th. The hospitality hour will be sponsored by the General Surgical Supply Company to which we have invited members from other organizations such as the Alabama Congress of Parents and Teachers and the Auburn University Co-operative Extension Service. We hope they will be in sympathy with our Health Careers Program and will help to recruit the young people in these paramedical fields.

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Mrs. James F. Crenshaw,

President



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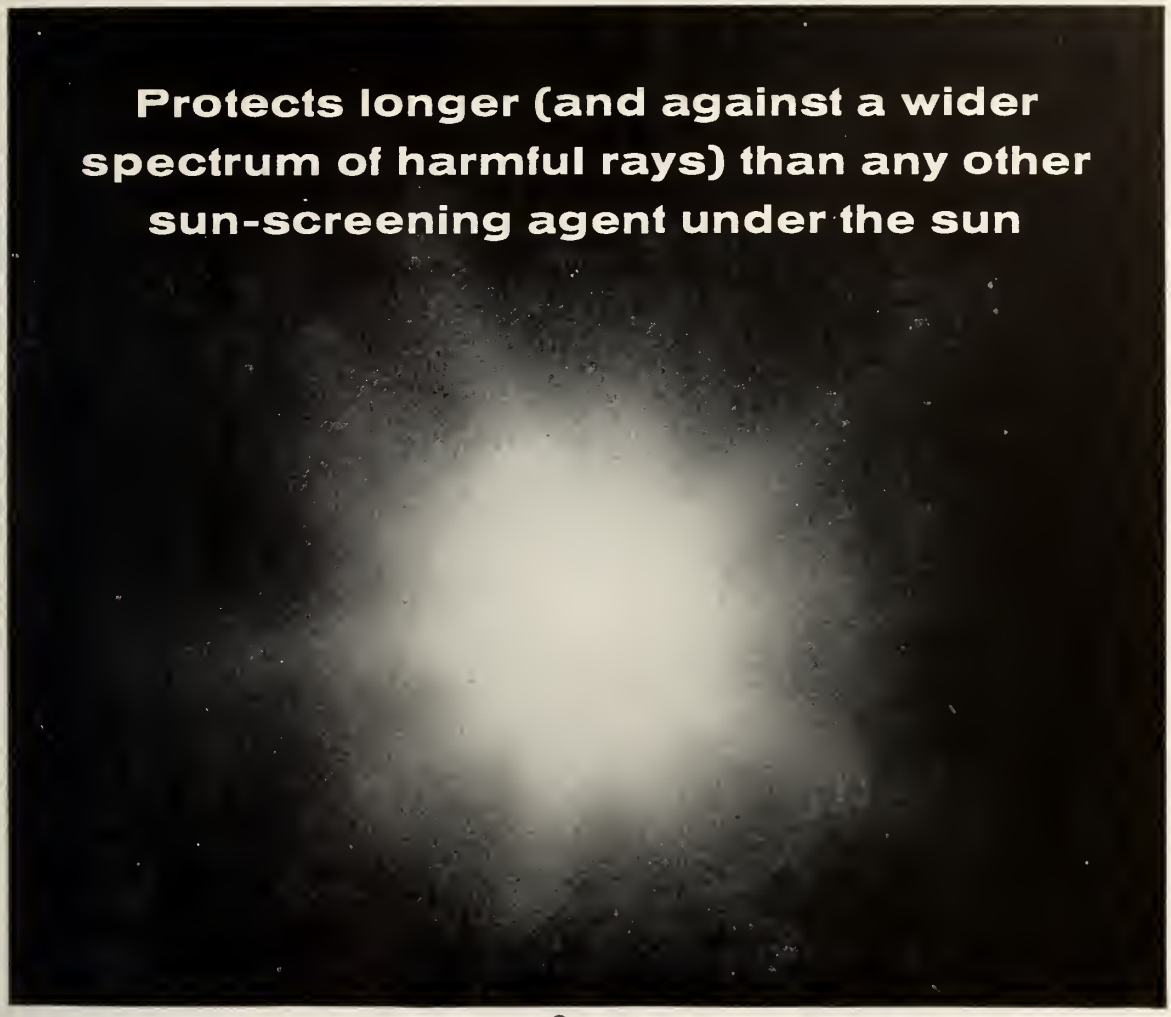
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. . . *"Recent Progress in Cancer Research"*
. . . *"Peripheral and Visceral Circulatory Disorders"*
. . . *"Molecular Biology and Genetics: Clinical Implications"*
. . . *"Psychotropic Drugs: Role in Clinical Practice"*
. . . *"The Subclavian Steal Syndrome and Other Neurovascular Disorders"*
. . . *"Shock, Burns, and Trauma"*

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THE SPEAKERS

DR. ROBERT J. HUEBNER, Chief of Laboratory of Infectious Diseases, Bethesda, Maryland
"Viruses—Current Advances and Clinical Implications"

(Continued on Page 235)

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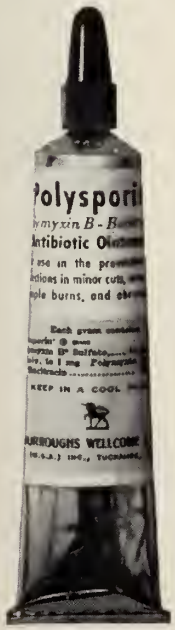
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"Hemorrhagic Enteropathy: A Common, Fatal Disorder"

DR. JOHN BEAL, Professor and Chairman, Department of Surgery, Northwestern

"Diagnostic Methods in Biliary Tract Disease"

DR. M. S. DeWEESE, Professor and Chairman, Department of Surgery, University of Missouri

"Mechanistic Approach to Thromboembolism"

DR. J. LAWTON SMITH, Associate Professor of Ophthalmology and Neurosurgery, University of Miami School of Medicine

DR. CHARLES ZUKOSKI, JR., Assistant Professor of Surgery, Veterans Administration Hospital, Nashville, Tennessee

"Organ Transplantation: Clinical and Experimental"

DR. DAVID SMITH, Assistant Professor, Department of Pediatrics, University of Wisconsin

"Congenital Malformations: Genetic Considerations"

DR. HOWARD JONES, Associate Professor of Gynecology and Obstetrics, Johns Hopkins University

"The Clinical Significance of Anomalies of Sex Chromosomes"

DR. LOUIS LASAGNA, Associate Professor of Medicine, Pharmacology, and Experimental Therapeutics, Johns Hopkins Hospital

"Precautions and Pitfalls in Prescribing"

DR. ROBERT HEATH, Professor and Chairman, Department of Psychiatry and Neurology, Tulane University

DR. THOMAS NEWTON, Assistant Professor of Radiology, University of California

"Visceral Angiography: A New Radiologic Aid in Diagnosis"

DR. DANIEL SCIARRA, Associate Professor of Clinical Neurology, College of Physicians and Surgeons, Columbia University
Attending Neurologist, New York Neurologic Institute

"Cervical Spondylosis and Osteoarthritis of the Spine"

DR. PETER FORSHAM, Professor of Medicine, University of California

"Short Cuts in Endocrine Diagnosis"

DR. GEORGE SCHREINER, Professor of Medicine and Director of Renal Division, Georgetown University

"Indications for and Interpretation of Renal Biopsy"

DR. W. PROCTOR HARVEY, Professor of Medicine, Georgetown University

"Cardiac Auscultation: Current Concepts"

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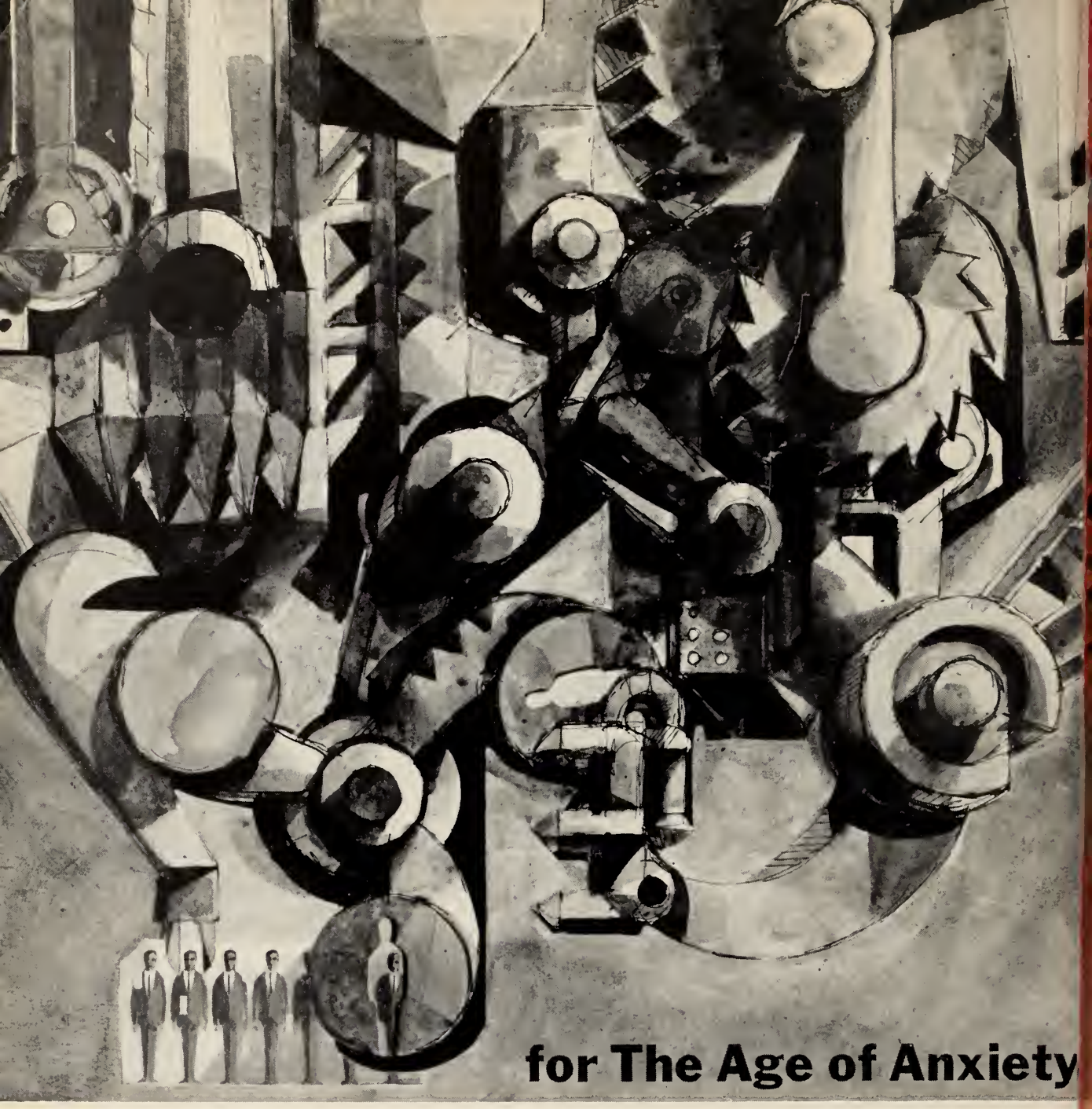
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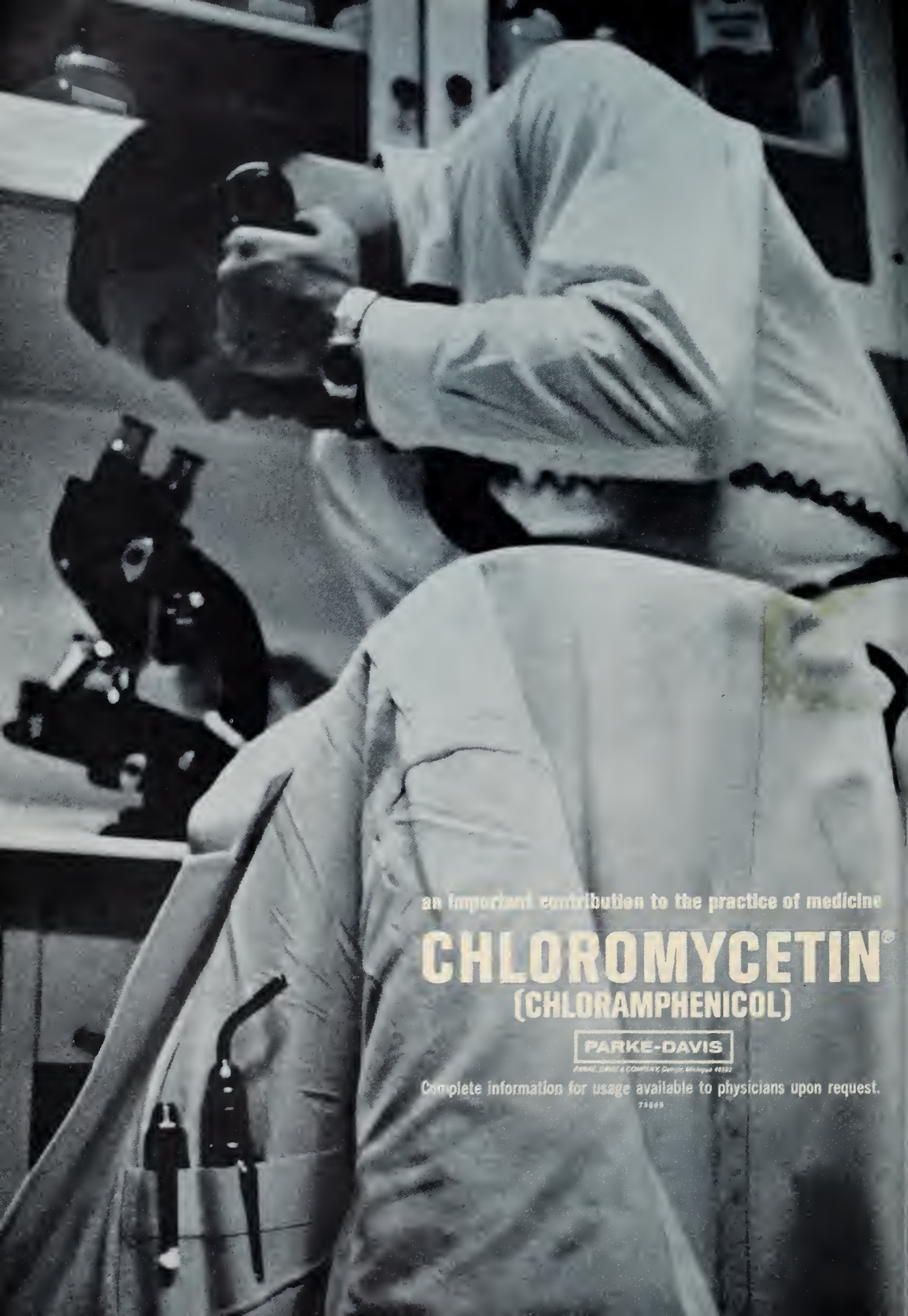
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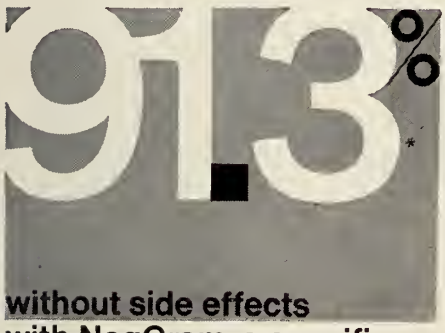
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*of a total of 1049 patients treated (Cooperative Study, Department of Medical Research, Winthrop Lab.)

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

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How supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1,000. **250 mg. for children,** available in bottles of 56 and 1,000.

References: (1) Carroll, G.: Urologists' Letter Club, June 1, 1964. (2) McDonald, D. F., and Short, H. B.: Address to the Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, New York, Oct. 26-28, 1964.

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President's Page



The Regular session of the Legislature of the State of Alabama was adjourned on August 26th, 1965. A number of important laws were passed which are of considerable interest to members of the medical profession. Since the Medical Association is by law the State Board of Health, all the members of the State Board of Censors and officers of the Medical Association were intimately involved in these legislative activities.

In November, 1964, at the call of the then President, Dr. E. B. Glenn, there was a special meeting of the Counsellors and Delegates of the Medical Association in Montgomery for the specific purpose of receiving from Dr. Ira L. Myers a description of the critical needs in the Department of Health. In accordance with a resolution adopted by the Medical Association at that time, an all-out campaign commenced which was designed to give relief to the most immediate needs in the Department of Health. The members of the Medical Association throughout the state are to be congratulated upon their response to this urgent request for help. The Vice-Presidents of the Association arranged regional meetings, at which Dr. Myers discussed the problem with members of local medical societies and invited members of the legislative delegations of these various sections of the state. Following this, an all-out educational campaign was organized with the help of Mr. L. P. Patterson in the central office. As the Legislature began its deliberations in the early summer, a delegation from the Medical Association met with Governor George Wallace to seek his help in satisfying the needs of the Health Department. Urgent requests were sent to the presidents and legislative chairmen in the various county medical societies for an intensive campaign with the local members of the Legislature to make sure that they were acquainted with the need and with the proposed solution. As a consequence of these efforts and with the excellent support from the Administration and from all members of both Houses of the Legislature, two bills were passed which gave significant help to the State Health Officer and the Department of Public Health in their efforts to improve health services to the people of the State of Alabama. One of these bills eliminated the salary ceiling for professional personnel in the Department of Health, so that more professional help could be obtained. A second bill imposed a one cent tax on each package of cigarettes sold, with the funds to be earmarked for the Health Department. Sixty per cent of the funds obtained from this new tax will go to the Department of Health

and approximately 40 per cent will go to the new Department of Mental Health. It is estimated that this tax will bring the Department of Health approximately $2,000,000 in additional revenue each year. With this additional financial support and with the authority to procure professional personnel at more realistic salary levels, the State Health Officer can now begin to upgrade the health services in his department which have been so critically deficient.

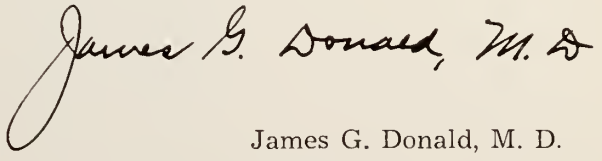
Another piece of legislation of far reaching significance was the creation of a new Department of Mental Health which would embrace all the hospitals for the care of the mentally ill and all other agencies related to mental health. This bill was a compromise measure worked out through the efforts of a subcommittee of the Board of Censors meeting with an Interim Legislative Committee appointed for this purpose.

A third most important piece of legislation was passed during the special session in the spring. This bill created a special Board for Medical Scholarship Awards and allocated sufficient funds each year to establish 60 loan scholarships for medical students of $2,000 each year, the loans to be repaid after graduation by service in the smaller communities of the state, or by repayment in cash with interest. In addition, eight merit scholarships of $2,000 per year were established for the Medical School. These are gift scholarships to be awarded to outstanding students who have earned them by their own merit.

A number of other bills were passed which are of interest to the medical profession. For example, a Battered Child Law requires that any physician, hospital, or other individual who knows of a child having been abused be required by law to report the same immediately to the Judge of the Juvenile Court, or to the Department of Welfare so that appropriate measures can be taken for further protection of the child or children. The per diem allotment for the care of tuberculosis patients in the various sanatoria was increased to $7.25 per day. Another bill was passed making phenylketonuria testing of infants compulsory in an effort to prevent mental retardation. A new Nursing Practice Act was passed.

We should all be proud of the fact that the cigarette tax bill to provide new funds for the Department of Health passed both Houses of the Legislature **unanimously.** This means that the members of the Medical Association of the State of Alabama and of the constituent county medical societies diligently performed their duty by informing their own local legislators of the desperate health needs of the people of the state.

The Alabama Chapter of the American Academy of General Practice is to be strongly commended for the "Physician For A Day" service at the State Capitol during the legislative sessions. Not only did doctors on duty lend a significant service in handling the emergency medical needs of the members of the legislature, but the personal contact with the Senators and Representatives afforded an opportunity for personal appeals for legislative relief, to the serious financial needs of the Health Department. The success of our legislative endeavors during 1965 is a direct result of long range and continuing legislative planning and of widely based legislative support at the local level. These two factors must be kept in mind for guidance in future legislative endeavors. The Board of Censors, the Board of Trustees, and the Committee on Legislation will be asked to immediately begin to plan for future legislative activities of interest to the Medical Association and attempt to design a more efficient system for utilization of local support in close liaison with a streamlined central legislative task force.



James G. Donald, M. D.
President

STATE AND NATIONAL MEETINGS SCHEDULED

Many New Features At AMA Clinical Convention

A comprehensive scientific program, a new postgraduate course, and special clinical workshops are some of the features of the American Medical Association's 19th Clinical Convention, November 28-December 1, in Philadelphia.

More than 300 physicians will participate in giving the four-day program of lectures, exhibits, motion pictures, color television, fireside conferences, and breakfast roundtables.

An outstanding scientific program is designed to hold special interest for the practitioner. Some topics to be covered: ulcerative colitis, gram-negative bacterial infections, a medical-surgical review of cardiovascular surgery, drug therapy in rheumatology, and cancer chemotherapy and preventive surgery.

The practicing physician will be able to participate in one of the convention's new features. Clinical workshops on diabetes, examination of the heart, management of common eye problems, and the solution of selected diagnostic and therapeutic problems will be conducted by outstanding teachers.

Also new will be a postgraduate course in cardiovascular therapeutics. It will be offered in addition to the popular course on gynecology and obstetrics begun at the clinical convention last year in Miami.

The annual AMA conference on the Medical Aspects of Sports will be held the first day of the meeting, November 28, in the Benjamin Franklin Hotel. It will be of special interest to high school and college team physicians.

There will be approximately 100 scientific exhibits, and 30 medical motion pictures.

Color television will be presented on the stage of the Civic Center in cooperation with the Hospital of the University of Pennsylvania. The subjects of six programs, to be followed by discussion, are "Lymphocytes, Cellular Immunities and Tissue Transplantation," "Renal Hypertension," "Pulmonary Resection," "Pulmonary Function Studies," "Surgical Aspects of Thyroid Diseases," and "Medical Aspects of Thyroid Diseases."

Twelve fireside conferences will be held Sunday evening, November 28, at the Warwick Hotel. They will be joint sessions of the American College of Chest Physicians and the AMA.

W. Emory Burnett, M. D., is general chairman of the meeting. Donald A. Dupler, M. D., is chairman of the scientific program committee.

Tuscaloosa Fall Meeting

The Tuscaloosa Chapter of the Alabama Academy of General Practice is pleased to announce a seminar to be held on November 12 in Tuscaloosa. Speakers from throughout the country will speak on a variety of subjects to include allergy, psychiatry, intra-uterine contraceptive devices, plastic surgery, cardiovascular diseases and an equal number of subjects yet to be announced. A final program will be forwarded at a later date.

(Continued on Page 244)



the sedentary life is often the seat of low back pain

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

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Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strains

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The University of Alabama plays the University of South Carolina at 2:00 P. M. on Saturday, the thirteenth. Tickets are now available in limited numbers, as are hotel and motel accommodations. In order to insure accommodations, we suggest early applications.

A speaker of note will talk to us at a breakfast in the Hotel Stafford on Saturday morning.

Dinner, to include a cocktail party and Las Vegas evening, offer gaiety on the evening of the twelfth.

The Tuscaloosa Country Club and Indian Hills Country Club golf courses will be open for use of attending physicians on Thursday and Friday, November 11th and 12th.

Symposium on Clinical Aspects of Hodgkin's Disease

November 22, 1965

Sutton Ballroom

New York Hilton Hotel

New York, New York

SPONSORS: American Cancer Society, Inc.—National Cancer Institute.

Morning Session—9:30 A. M.-12:30 P. M.

Moderator—Dr. Kenneth Endicott, Director, National Cancer Institute

THE CLINICAL FEATURES AND DIAGNOSIS OF HODGKIN'S DISEASE

Dr. John E. Ultmann, Columbia Presbyterian Medical Center, New York, New York

THE IMMUNOLOGIC STATUS OF HODGKIN'S DISEASE

Dr. Alan Aisenberg, Massachusetts General Hospital, Boston, Massachusetts

THE NATURAL HISTORY OF HODGKIN'S DISEASE AS RELATED TO ITS PATHOLOGIC PICTURE

Dr. Robert J. Lukes, University of Southern California, Los Angeles, California

THE NATURAL HISTORY OF HODGKIN'S DISEASE AS RELATED TO STAGING

Dr. M. Vera Peters, The Princess Margaret Hospital, Toronto, Canada

QUESTION AND ANSWER PERIOD

Afternoon Session—2:00 P. M.-5:00 P. M.

Moderator—Dr. Leonard Larson, President, American Cancer Society, Inc.

THE TREATMENT OF HODGKIN'S DISEASE WITH RADIOTHERAPY

Dr. Henry S. Kaplan, Stanford University Medical Center, Palo Alto, California

THE TREATMENT OF HODGKIN'S DISEASE WITH CHEMOTHERAPY

Dr. David A. Karnofsky, Sloan-Kettering Institute for Cancer Research, New York, New York

THE TREATMENT OF HODGKIN'S DISEASE WITH NEWER THERAPEUTIC APPROACHES

Dr. Emil Frei, III, M. D., Anderson Hospital and Tumor Institute, The University of Texas, Houston, Texas

THE OBJECTIVE ROLE OF SURGERY IN THE TREATMENT OF HODGKIN'S DISEASE

Dr. James T. Grace, Roswell Park Memorial Institute, Buffalo, New York

THE POSSIBILITIES FOR THE CURE OF HODGKIN'S DISEASE

Dr. Eric C. Easson, Christie Hospital and Holt Radium Institute, Manchester, England

QUESTION AND ANSWER PERIOD

SUMMARY AND CONCLUSIONS

Dr. Sidney Farber, Children's Cancer Research Foundation, Boston, Massachusetts

(Continued on Page 272)

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References: 1. Goldsmith, J. W.: Minn. Med. (Feb.) 1957. 2. Groskloss, H. H., Clancy, C. L., Healey, E. F., McCann, W. J., Maloney, F. D., Loritz, A. F.: Clinical Medicine (Sept.) 1955. 3. Codling, J. W., Lowden, R. J.: Northwest Med. (March) 1958. 4. Bethea, R. C.: International Record of Med. (May) 1960. 5. Lenz, W., Second International Conference on Congenital Malformations, N. Y., N. Y., (July) 1963.

Side effects: the incidence of drowsiness and other atropine-like effects is low. However, caution patients engaged in activities where alertness is mandatory.



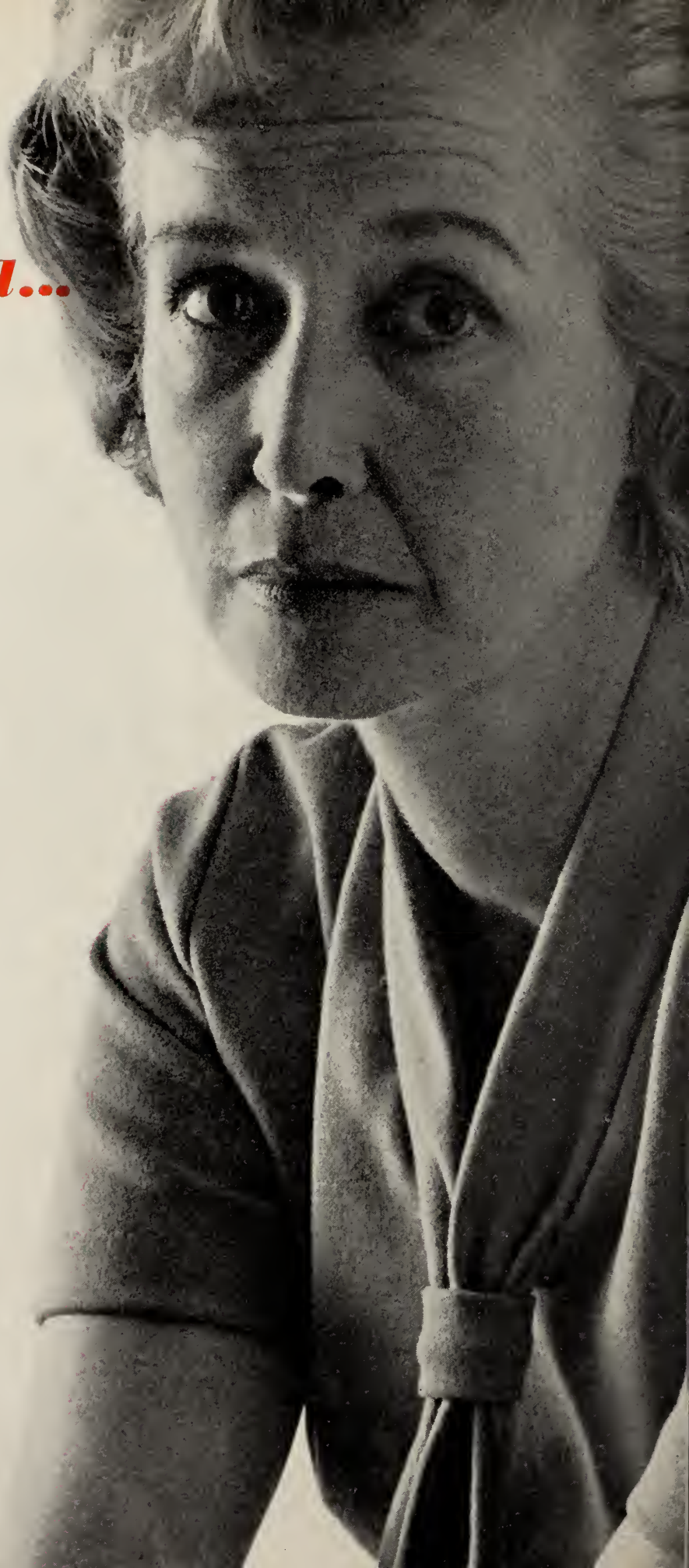
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*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.

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Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

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Side Effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

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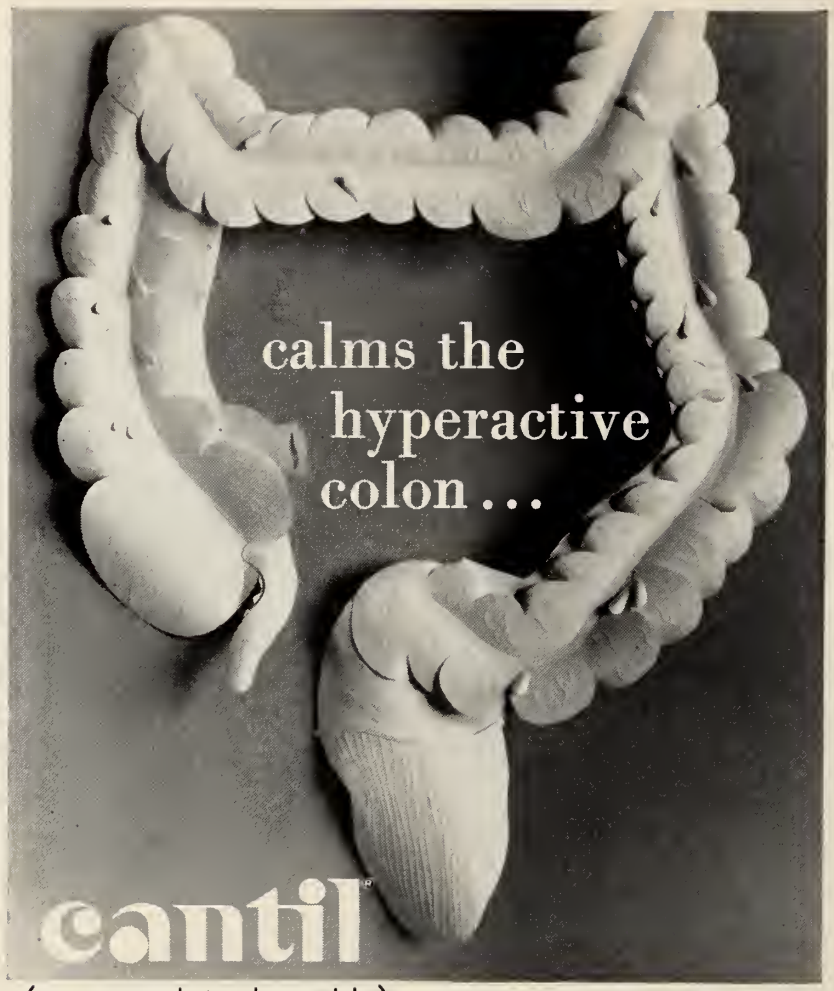
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1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—Despite the flood of major health measures approved by Congress this year, President Johnson apparently plans to propose more important health legislation next year. Health has been given no. 1 priority on the "great society" program, it appears.

Johnson has been telling Congressmen to think in terms of even greater strides next year.

To lay the groundwork for new legislation, he has called a White House Conference on Health November 3-4.

Johnson recently took the occasion of signing two health bills to outline his health goals:

—An increase in the average life expectancy from the present 70 years to 75 years.

—A reduction in infant mortality from the present rate of 25 deaths per 1000 births to 16 per 1000.

Virtual elimination of polio, diphtheria and typhoid fever and an end to tuberculosis, measles and whooping cough.

—A reduction of 20 per cent in deaths from heart disease, cancer and stroke—the so-called "killer diseases" that now account for one-third of all U. S. deaths.

—Elimination of death and disability among children caused by rheumatic fever and rheumatic heart disease.

—Eradication of malaria and cholera from the entire world.

One of these two health bills he signed into law authorizes a three-year, $280 million extension of the Health Research Facilities Act. It also authorizes three additional Assistant Secretaries of HEW, one for Health and Medical Affairs. A special assistant to the secretary had been the top official for Health and Medical Affairs.

The other bill amends the Vaccination Assistance Act and extends it for five years. It authorizes Federal expenditures of $8 million a year, broadens the program to include measles and any other disease designated by the Surgeon General of the Public Health Service and makes the immunization program a continuing one, rather than "an intensive community vaccination (program) of limited duration." Expenditure of $45 million during the next five years also is authorized for family health clinics for migratory workers.

Neither the chairman nor the vice chairman of the White House Conference on Health is a physician. However, five of the nine members of the executive committee to plan for the conference are physicians. All were appointed by Johnson.

George Beadle, Ph.D., president of the University of Chicago, will be chairman and Boisfeuillet Jones, former special assistant to the HEW Secretary, vice chairman.

Physicians on the executive committee are Dwight L. Wilbur of San Francisco, a member of the Board of Trustees of AMA; George James, New York health commissioner; Lowell T. Coggeshall, trustee and former dean of the Medical School, University of Chicago; Montague Cobb, professor of anatomy, Howard University Medical School and former president of the National Medical Association, and Michael E. DeBakey, professor of surgery, Baylor University.

The chief executive said the purpose of the conference is to bring together "the best minds and the boldest ideas to deal with the

(Continued on Page 256)

"...it is extremely difficult and sometimes impossible to differentiate between 'pure depression' and anxiety and it is questionable whether depression without a certain degree of anxiety really exists."

Lehmann, H. E., Canad. Psychiat. Assn. J. *4(S)*: 1-12, 1959



An antidepressant designed for the clinical realities of office practice

As many physicians have reported, the large majority of neurotic depressed patients suffer from both depression and anxiety. It may be difficult to decide whether these patients are primarily depressed or primarily anxious. And yet drug treatment of only the symptom which seems more prominent may exacerbate the untreated element of the depression complex.

Consequently, it would seem that therapy specifically aimed at both the depression and associated anxiety and tension should increase success in treatment.

This is one of the important reasons why 'Deprol' has proved particularly helpful. For 'Deprol' acts rapidly both to lift the mood and to relieve the associated anxiety, tension and insomnia.

And side effects, at recommended dosage, have been infrequent and generally readily controlled.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

Before prescribing, consult package circular. CD-5749

Deprol®

meprobamate 400 mg. +
benactyzine hydrochloride 1 mg.

WALLACE LABORATORIES / Cranbury, N.J.

(Continued from Page 253)

pressing health needs of the nation." He said he hopes the conference will develop "creative programs that will bring better health to every American."

* * *

The Food and Drug Administration issued two proposals designed to eliminate possible causes of illness. One called for a reduction in the amount of vitamin D added to food products and the other for pasteurization of commercial egg products.

Last November Dr. Robert Cooke of Johns Hopkins University expressed concern that the ingestion of excessive amounts of vitamin D was a possible cause of infantile hypercalcemia. FDA Commissioner George P. Larrick then invited the Committee on Nutrition of the American Academy of Pediatrics and a joint Committee of the Council on Foods and Nutrition and the Council on Drugs of the American Medical Association to look into this problem.

Both committees recommended that, while there has been no positive demonstration of a cause and effect relationship of vitamin D to this disease, there should be restrictions on the marketing of foods containing added vitamin D.

The committee made clear that there is abundant scientific evidence to demonstrate that an excessive intake of vitamin D is of no value and that 400 USP units per day will meet the full requirements of infants, children and nursing mothers.

Larrick concluded that "prudence" called on limiting the amount of the vitamin added to foods.

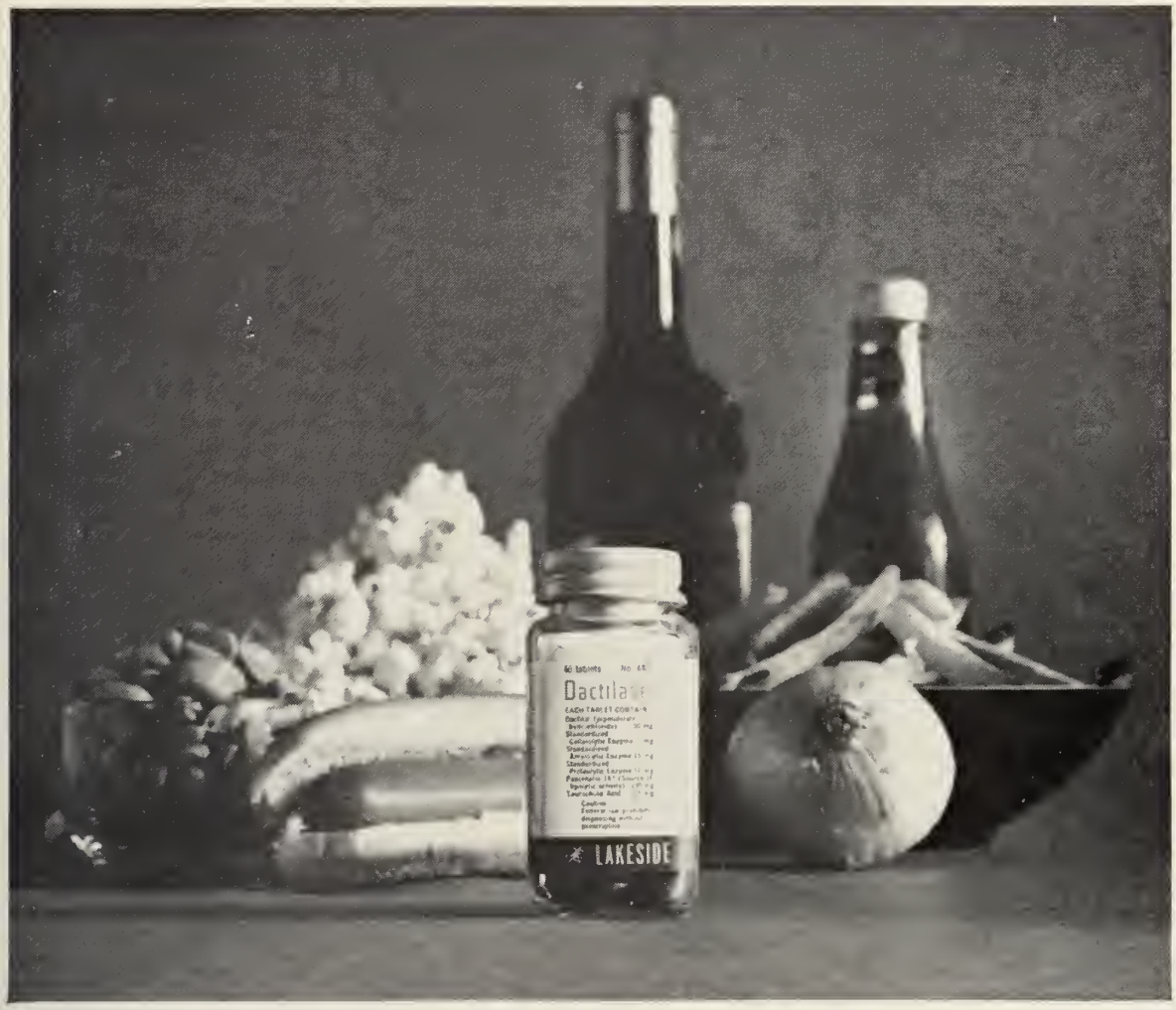
The proposal would permit the continued addition of vitamin D to such foods as milk, milk products and infant formulas at a level of 400 USP units per quart. Over the counter vitamin D preparations would be limited to a dosage of 400 USP units of vitamin D per day. Vitamin D preparations containing over 400 USP units per day would be sold only on prescription. The proposal would deny authority for the addition of vitamin D to standardized foods such as enriched flour, enriched corn meal, enriched rice, enriched macaroni products, enriched bread and margarine.

Requiring pasteurization of commercial egg products was aimed at eliminating possible hazards to consumers from Salmonella bacteria in foods that contain eggs. During the past fiscal year, 220,150 pounds of egg products were seized for Salmonella contamination. Such products are used as ingredients in many other foods, including premixed and ready-to-eat foods that the housewife uses. Egg products containing Salmonella have been implicated in cases of food-caused illness in men.



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Reprinted from: "The New Physician"



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*Need in human nutrition not established. **As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

Side Effects and Contraindications: DACTILASE is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

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MEDICAL PROGRESS ASSEMBLY



In the Hospitality Room at the Medical Progress Assembly (left to right), Dr. Leslie W. Johnson, Dothan, Dr. Bobbie LeMay, Resident, Medical College of Alabama, Dr. Joe D. Bonds, Albertville, and Dr. Harold J. Kelly, Muscle Shoals.

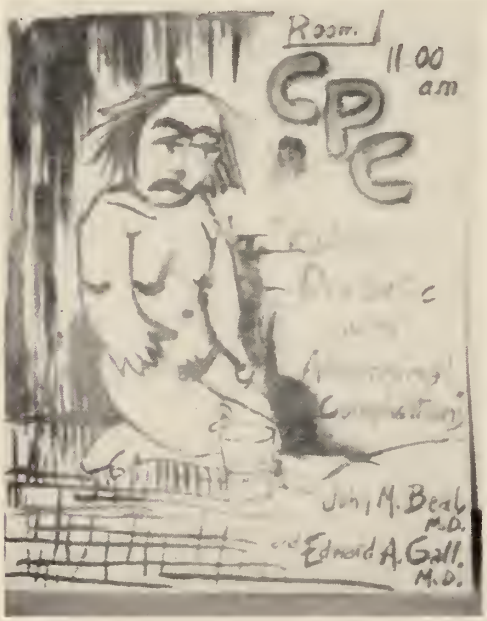


Shown just after a panel discussion are Dr. George E. Schreiner, Washington, D. C., Dr. W. L. Lawrence, Moderator, Birmingham, Dr. W. Proctor Harvey, Washington, D. C., and Dr. Peter H. Forsham, San Francisco, California.





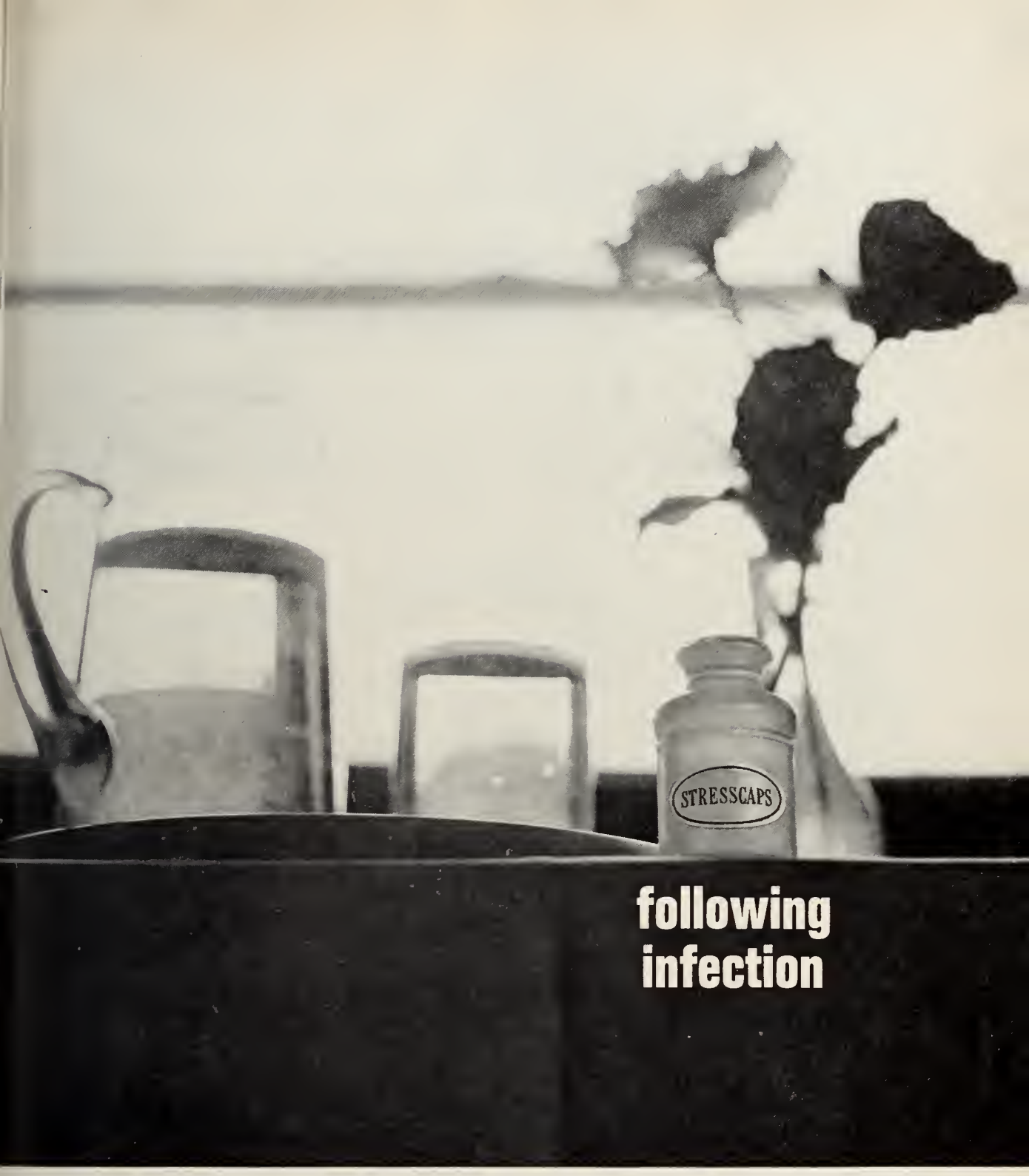
JUST BEFORE THE BANQUET—Dr. S. Richardson Hill, Dean, Medical College, Mrs. Hill, and Speaker, Dr. Peter H. Forsham, San Francisco, California. Dr. W. R. Robertson, Mrs. A. R. Dimick, Mrs. W. H. Robertson, Birmingham, and Dr. Howard Jones, Speaker, from Baltimore, Maryland.





(Above) Dr. J. Lawton Smith, Miami, Florida, Dr. W. L. Hawley, Moderator, Birmingham, and Dr. M. S. DeWeese, Columbia, Missouri.

(Left) Poster drawn by Dr. Ricardo Ceballos, Department of Pathology, Medical College of Alabama, used to illustrate the "Elderly Diabetic with Abdominal Complications" during one of the Panel discussions.



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Niacinamide	100 mg.
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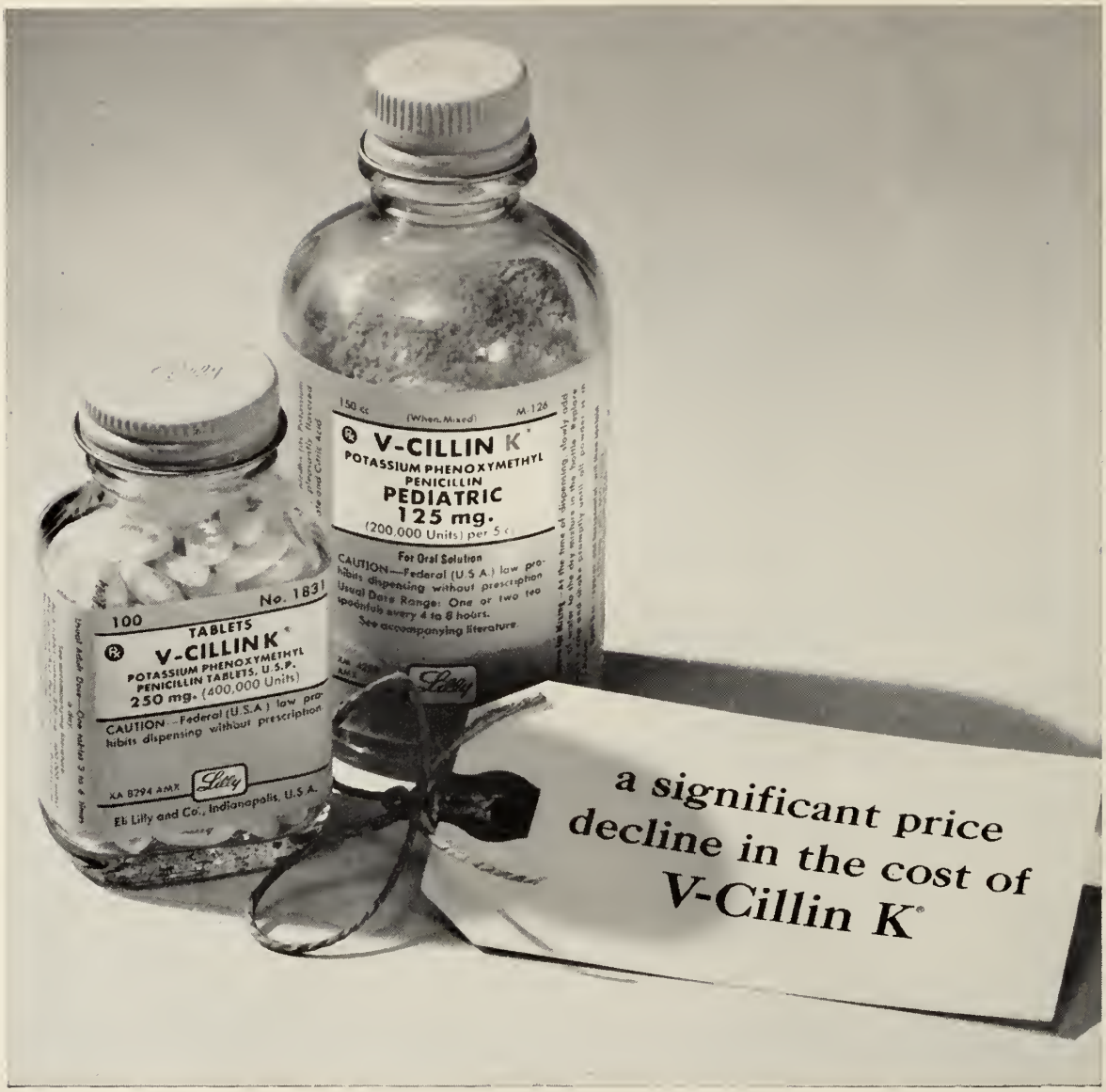
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THE JOURNAL

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The Changing Concepts of Early Cancer*

William M. Christopherson, M. D.

Professor and Chairman Department of Pathology

University of Louisville School of Medicine

It is indeed a signal honor to have been invited to deliver the Jerome Cochrane Memorial Lecture. Having reviewed the list of my predecessors who have participated in this event, it is with some temerity that I approach the undertaking.

This society and the state of Alabama have contributed greatly to the ever increasing knowledge of medical science. Your contribution of renowned physicians and surgeons is universally acknowledged. I have learned that Jerome Cochrane was a real giant among the greats you have contributed. He contributed to this association in its founding days and left his mark on the structure of the Medical Association of the state of Alabama and the medical practice in this state. He was a leader in establishing effective public health measures which remain operational throughout the United States today.

Jerome Cochrane was born in Moscow, Tennessee in 1831. He grew up in Marshall County, Mississippi. In 1857 he graduated from the Botanic Medical college of Memphis, and subsequently again graduated in 1861 from the medical department of the University of Nashville. I was not surprised to learn that at both colleges he was elected valedictorian of the graduating class. After serving as a surgeon in the Confederate Army, he settled in Mobile and soon built a flourishing practice. In 1868 he became Professor of Chemistry at the Medical College of Alabama, and later was also to assume the professorship of Public Hygiene and Medical Jurisprudence. His latter years were spent in Montgomery, where he died in 1896.

At the risk of doing Dr. Cochrane an injustice, I would suggest that he made three major contributions to the state and to the nation. In 1873 he wrote the constitution of the Medical Association of Alabama, and I quote "made that association the most powerful medical organization in the U. S. A."[1] In

*The Jerome Cochrane Lecture 104 Annual Session of The Medical Association of the state of Alabama.

1875 he drafted the act to establish Boards of Health in the state of Alabama. This act was to serve as a model for the formation of many other Boards of Health. In 1877 he wrote the act to regulate the practice of medicine in the state of Alabama. To put these deeds in their proper perspective, Dr. Cochrane did not approve of the California and Massachusetts systems, where the members of the State Board of Health were political appointments. He not only set about to defeat this type of plan in Alabama, but he submitted his own, which was enacted into law and which makes the State Medical Association responsible for the functions and powers of the State Board of Health, and the County Medical Societies responsible for carrying out the same duties for the County Boards of Health.

I was able to accumulate only a small portion of Dr. Cochrane's writings. The striking feature of these would seem to me to be the great diversification of his interests and abilities. The titles range from "The White Blood Corpuscle and Its Physiology and Pathology," to "Problems in Regard to Yellow Fever and the Prevention of Yellow Fever Epidemics." He apparently knew more about yellow fever than any man of his time.

The medical problems in Alabama between 1831 and 1896 were obviously greatly different than the problems of today. It is not surprising that there was little evidence that much thought was given to cancer, since cancer was listed as a relatively unimportant cause of death; actually preceded by 11 other disease entities. Today it is preceded only by heart disease. It is noted that in 1890, although heart disease was the third most common cause of death, consumption killed twice as many people. From this we can better appreciate the tremendous changes in patterns of disease over a relatively short period of time.

In 1870 there were fewer than one million people in the state of Alabama. The death rate was well below the national average—10.8 per thousand population as compared with 12.77 per thousand population for the nation as a whole. The growth of the state was steady. By 1880 the population had increased to one and a half million. In that year there were over 20,000 deaths, with only 290 of these attributed to cancer. It is of particular interest, in view of present experience, that only seven cases of cancer of the uterus were diagnosed in this state during that year.

In view of the relatively few reported cases of cancer, it is not surprising that public health officials with other pressing problems had not undertaken the somewhat disheartening and expensive problem of cancer control.

In the year of Dr. Cochrane's death, the appropriation for the Alabama State Board of Health was $13,000.00. Having faced several epidemics, among them the great yellow fever epidemic of 1874, the coffer had undoubtedly been emptied in an attempt to solve the problems of sanitation, vaccination, quarantine, and so forth. How could Alabama have had such an exemplary Board of Health with such a small budget? In view of the tremendous amount of money being spent today on Public Health measures, it is difficult to visualize how Dr. Cochrane and his contemporaries could have accomplished so much with so little. On a comparative basis $13,000.00 does not seem so little. The budget in my own state of Kentucky in 1896 and 1897 for the State Board of Health was only $2,500.00—$1,200.00 was spent as a salary for the physician who was secretary of the Board of Health, and interestingly enough one item listed in the budget was, "$150 for the salary of a typewriter."

The threefold increase in cancer since 1890, with the concomitant decrease in infectious diseases, has certainly realigned medical problems. Today cancer is the most feared disease of man. In 1890 one was indeed fortunate to survive the many epidemics and attain the age where cancer would become a major threat. Much more important than the increase in rates has been the relatively recent change in the concept of cancer. It is no longer a hopeless disease which is not dis-

cussed in polite society, but rather to an extent a preventable, and in its early stage, a highly curable disease.

Virchow, probably more than any other man, influenced the opinions of the great physicians of the past few decades. His concept that without definite tissue invasion there could be no cancer was universally respected. In the past two decades we have regarded this concept as being therapeutically nihilistic. There is now a growing body of evidence that cannot be ignored to support the fact that invasive carcinoma evolves as a gradual process of field cancerization. In its pathogenesis there must be a stage at which invasion has not yet occurred. Fred Stewart has stated the fact briefly and logically—"Every infiltrative cervix cancer must come from in situ cancer, there being no other thing it can come from, this irrespective of various doubts cast on the relationship."[2] This must also apply to cancer of other sites; however, as logical as it seems to us now, it was a long time in evolving. Nonetheless it has been a great conceptual development in the cancer field and offers some hope of control of the disease. The fact has been established that cancer, if detected early enough, is highly curable.

The other concept, that cancer is a preventable disease, was a tremendous step forward. Epidemiological studies of cancer are not a recent innovation. As early as 1775, Sir Percival Pott observed the relationship between cancer of the scrotum in chimney sweeps and their occupation. We might reflect that it took over 140 years to get experimental confirmation of Pott's basic observation. In spite of this, scrotal cancer was controlled by the simple public health expediency of eliminating the soot from the clothing and skin of boys who climbed up and down the chimneys of England. Scrotal cancer is still occasionally seen in chimney sweeps; however, it is seen in adults of an age rather similar to that of scrotal cancer in the general population.

A large number of carcinogenic agents in our environment have in fact been identified. Although few of these are presently known to be of clinical significance, some are of considerable importance because they offer the possibility of effective cancer control through the elimination of contact.

Several years ago while reviewing the old material in our laboratory, I was quite surprised to observe that at the time of the First World War there were many more cases of carcinoma of the penis than carcinoma of the lung treated in our hospital. At that time it was not at all uncommon to find skin cancers arising from old burn scars or old draining sinus tracts. We rarely see examples of either of these today. Cancer of the penis we now know simply does not occur in males who have been circumcised early in life. The disease is absolutely preventable.

Public Health regulations and workman's compensation laws have done much to reduce the hazards of certain occupational cancers, such as carcinoma of the urinary bladder in aniline dye workers; bone sarcomas in radium dial painters; cutaneous cancers in petroleum workers, and lung cancers in uranium and cobalt miners, just to mention a few.

I think it fair to state that at the present moment we know a great deal more about causes of squamous cancer than of other forms. In addition to actinic ray cancer of the skin, there are three major sites of squamous carcinoma which lend themselves to control either through prevention or early detection at a subclinical stage. I would estimate that in round numbers these sites might represent as many as 90,000 new cases in the United States in 1965; this in addition to some 70,000 new cases of skin cancer.

The effective preventative measures for squamous carcinoma of the lung must be obvious to all of us, as unpopular as the evidence seems to be with certain groups. These same preventative measures should be effective in decreasing the incidence of carcinoma of the oral pharynx and larynx. They should be effective in decreasing the incidence of carcinoma of the esophagus, which, incidentally, at the present time is a greater problem

than gastric cancer in our own hospital and I suspect the same would be true in other hospitals caring for low income groups. Dr. Condict Moore of the University of Louisville has recently re-emphasized the importance of all types of smoking in the causation of oropharyngeal cancer, and has further shown that the rate for second primary cancers is alarmingly high if the tobacco habit continues after the successful treatment of the first primary lesion. For those who quit smoking after developing their first cancer there were relatively few second primary lesions.[3]

Unfortunately, as obvious as the relationship is between smoking and the rates of cancer of these sites, we have not developed effective measures of education nor are we having overwhelming success in breaking people of the tobacco habit. Apparently there are still a few physicians who even doubt the relationship, and many more who would ignore it or plead ignorance of information which substantiates the relationship. Meanwhile as we contemplate the problem, over 40,000 individuals in the United States will continue to die each year of bronchogenic carcinoma and perhaps another 6,000 of buccal cavity or pharynx cancer. Had the British waited 140 years for experimental proof that chimney soot could cause cancer of the skin, countless lives would have been needlessly lost. Furthermore, the medical profession of that great nation would have been rightfully entitled to severe criticism.

There is an alarming, almost epidemic increase in lung cancer in the United States, while other cancers are either remaining stationary or in the case of gastric carcinoma, decreasing significantly. There is no indication that the incidence rate has leveled off, and unfortunately an increase in the rate of lung cancer in women is now being observed. The relationship of the chances of developing lung cancer according to the smoking habits is so convincing that I need not belabor the point before this group.

The model for effective cancer control has to be the cervix uteri, both from the standpoint of prevention and early detection. I think it safe to say that there is no other major cancer about which so much is known concerning the prevention, early detection, natural history, and treatment. Cervix cancer, together with the less frequently encountered forms of uterine cancer, occurs in the state of Alabama at the rate of 1,100 per year. According to the American Cancer Society, the uterus is the most common site of cancer in Alabama, followed by breast, lung, and colon-rectum.[4]

The modern concept of early cancer has been attainable largely through careful studies of the cervix uteri. We now know, beyond all doubt, that cancer of this site, as well as cancers of other sites, develop over a protracted period of time. Cervical cancer is present ten to twelve years before it invades the stroma of the cervix and attains the status where it can give rise to metastasis. Furthermore, it remains occult in a microinvasive stage where it is asymptomatic and not likely to give rise to metastasis for another two or three years. During this early phase of the disease it is readily detectable by cytological examination and highly curable by relatively conservative measures. Deaths from this disease are by and large unnecessary deaths. Morbidity from the more advanced stages of the disease is just as unnecessary, if we would apply the presently available tools and knowledge to the problem.

Quite aside from the detection of cervical cancer at a time when it approaches 100 per cent curability, there is a large fund of knowledge concerning the prevention of cervix cancer. This is a disease which is practically nonexistent in women who live as celibates. It is extremely rare in Jewish women. It is more common in the marriage state than in single women. More common in the Negro. It has an incidence rate two and one half to three times as great in women in lower socioeconomic groups as compared to their more affluent sisters. It is extremely common in prostitutes and institutionalized women who have practiced the oldest profes-

sion. In a recent study to further identify the high risk groups, we found that 64 per cent of cervix cancer occurred in women who were either married or pregnant in their teens. In fact, it was more common if the women were pregnant or married, or both, before the age of 15 than if of similar status from the age 15 through 19. I must conclude, however, that preventative measures are much more apparent than practical. Nonetheless, early detection is both practical and urgent.

Carcinoma in situ or subclinical carcinoma of other sites is much more difficult to detect than carcinoma in situ of the cervix, although our files now have examples of carcinoma in situ of almost every organ, ranging from lung to stomach. For over 25 years Drs. Stewart and Foote at Memorical Hospital in New York have been interested in the non-invasive forms of breast cancer. Between 1940 and 1952 they collected 50 examples of lobular carcinoma in situ of the breast. Of these, nine had mastectomy and six were lost to follow up in less than five years. Of the remaining 35 cases, all initially treated by local excision only, 19 cases were followed from five to ten years and 16 cases from 10 to 21 years. Twelve of the patients had later surgery for breast cancer. Nine, or 25 per cent, had cancers in the homolateral breast, eight of these were infiltrating and one was carcinoma in situ. One of these patients also had an additional infiltrating cancer in the opposite breast. Three patients developed cancer in the opposite breast, two were infiltrating and one carcinoma in situ. Hence, there were 13 cancers in 12 patients—about 25 per cent homolateral and 10 per cent contralateral. It is of further interest to note that 32 per cent of these patients were under the age of 40, whereas only 15 per cent would be expected to be in this age group. On the other hand only 16 per cent were of the age 51 to 60, whereas 50 per cent would have been expected.[5] This indicates that carcinoma in situ of the breast, just as carcinoma in situ of the cervix, can be expected, and does occur at a much younger age than clinical cancer.

We are seeing more and more examples of this completely curable form of breast cancer and it is to be hoped the mammography will prove to be of value in detecting more examples of this disease. This hope was increased recently when our radiologist insisted on biopsying the opposite clinically benign breast of a woman who had radical surgery for an obvious clinical cancer. The excised tissue of the clinically benign breast looked entirely normal. The radiologist still insisted there must be cancer. Much to my surprise there were indeed lobular carcinoma in situ.

The changing concept of early cancer can be appreciated if one examines the photographs appearing in the textbooks of a few years ago. Patients with skin cancer were depicted with a major portion of their face destroyed. Salivary gland tumors appeared so advanced that they would defy any attempt to cure. One is in fact gazing at a book of horrors. Today we attempt to teach that a skin cancer is so inconspicuous at its onset that it appears completely innocuous. It may present as a slight thickening of the skin or an area of hyperkeratosis, but it is not the large rodent ulcer of yesteryear.

Those of us interested in the cytologic detection of cancer have hoped for success in areas other than the female genital tract. We have been partially rewarded with success in relatively inconspicuous oral lesions. We have all seen the occasional asymptomatic patient with a radiographically clear chest and cancer cells in the sputum. We have rarely been able to find an occult carcinoma in a diverticulum of a bladder by finding cancer cells in the urine. Much less frequent has been our success in detecting asymptomatic gastric cancer. Nonetheless, certain individuals, notably Schade in England, have been very successful in detecting early surface carcinoma of the stomach. Schade now has over 40 examples of such lesions cytologically detected.[6] The point is not that results in gen-

eral have been relatively disappointing, but more importantly that we now have new concepts and are willing to search for subclinical lesions. Until the etiological agent is isolated, the vaccine produced, or the selective chemical developed, our only real recourse is to rely on prevention and early detection, preferably at a subclinical level.

Let us not neglect our manifest duty to the people of Alabama and the rest of the world by any further delay in applying the available measures we know will succeed in the control of certain forms of cancer.

References

1. Stone, R. F.: Biology of Eminent American Physicians and Surgeons. Indianapolis, Carlon and Hollenbeck. 1894; pp. 92-93.

2. Stewart, F. W.: Factors influencing the curability of cancer. Proceedings of the Third National Cancer Conference. Philadelphia, Lippincott, 1957; pp. 62-73.

3. Moore, C.: Smoking and Cancer of the Mouth, Pharynx and Larynx. J. A. M. A. 191: 283-286; January, 1965.

4. American Cancer Society: 1965 Cancer Facts and Figures, pp. 7.

5. Foote, F. W., Jr.: Personal communication; March, 1965.

6. Schade, R. O. K.: Personal communication; May, 1965.

PROJECT VIET-NAM

In response to an urgent appeal to American Medicine by President Lyndon B. Johnson, the American Medical Association is assisting the newly formed voluntary organization known as PROJECT VIET-NAM. This Project, administered by The People-to-People Health Foundation, Inc., is a cooperative medical effort of America's inter-voluntary agencies for the people of South Viet-Nam. The Agency for International Development (AID) is also participating in this program that appears vital to our success in the present crisis in Asia.

PROJECT VIET-NAM was developed to help alleviate the problem of the critical shortage of physicians in South Viet-Nam—a problem that is crippling and demoralizing the civilian population of the country. The matter is of concern to all physicians—those believing that human life everywhere is sacred, and those sharing a stake in the security of the United States. The American Medical Association, cooperating with the President's request, is appealing to each County and State Society for participation in a program that will assist in the procurement of volunteer physicians for this important venture.

PROJECT VIET-NAM will send teams of twenty (20) physicians into Viet-Nam for periods of just **sixty (60)** days. The teams will be divided into four groups, each being assigned to a hospital now being operated under the AID program. Facilities and supporting personnel are available at each installation for carrying out services in accordance with acceptable professional standards. While ultimately many disciplines of medicine may be required, the immediate need is for physicians in **general practice, general surgery** and **orthopedic surgery.** Although service with PROJECT VIET-NAM is on a volunteer basis, transportation from home and return via commercial airline, a nominal per diem, housing, meals and other needs will be supplied. The federal government has also given assurance that all volunteers will be granted the same privileges, courtesies and priority provided government personnel in the area.

Interested physicians may obtain further information and application forms by communicating with:

PROJECT VIET-NAM

2233 Wisconsin Avenue, N. W.

Washington, D. C. 20007

Phone: 338-5730 or 338-6110

Reflections Concerning Children And Organized Sports

D. J. Judge, M. D., F. A. A. P.

Anniston, Alabama

Many of us who work with children have been concerned about the welfare of young athletes, (boys from the farm league up to the varsity high school level). The major concern is that children have been pressured into regimented competition for the purpose of "winning the game" to either glorify themselves, their mothers and fathers, their coach, or their sponsors.

I am not speaking as one who has never experienced competitive sports nor one without a definite interest in active sports participation.

Boys and girls like to win and to win or do their best is important in every game, in any contest, in the competition of every day life.

We are proud of the team that wins, especially if it is our team or if our youngster is on that team. Winning is *NOT* the important thing in the early stages of development. Good physical condition, good habits, the fundamentals, learning to perform in a contest properly and safely, learning good sportsmanship, learning by participating in many contests under a wide variety of circumstances are the lessons that should be learned well at first.

Just plain having *FUN* is more important than the final score, (which most often is forgotten by the time the season is over or by the time the next game comes along) is missing from most little league games. How you play the game, whether you win or lose, has been replaced by the comments like "nice guys finish last." There are many "nice guys" in sports and there is still glory in bigtime sports when an athlete does his best even though he isn't the winner. All athletes look back to the man that got him started. His father or coach or just someone who was interested, who told him how to bunt, hit a big serve or stroke a putt.

A genuine desire to be helpful, useful, to encourage and direct young people motivates most coaches. Otherwise, they would not spend their time teaching young people. We are proud to have these people. There are some men however, who although they start with these motives, soon consciously or unconsciously try to fulfill a desire within themselves to be famous or to produce a winning team or to get some glory.

Then there is the pressure of the parents or sponsors. There is nothing quite as distasteful as to see a parent shout from the stands and berate a child for not doing well, or

further, to berate an umpire who is doing well at the job no one likes. Nobody ever became a champion by having things go his way all the time and a mark of a champion is to take the bad breaks. A good player or team makes the breaks, but no matter how good the team, they can't have the breaks all the time. The champion overcomes the bad breaks and seems to have more good ones.

Fun. Fun should be synonymous with sports. Young people should be taught the fundamentals of fitness, the fundamentals of a game, then participate in a game to enjoy it.

Why is it that most children today hate to practice?

Practice is fun to most athletes. Willie Mays is the first man out for the "pepper game" and the last one to put down his glove. Babe Ruth would stop by a sand lot and play ball with the kids. Lou Gehrig, in the streets, played stick ball after a major leage ball game. That is because these people enjoyed the sport and played not for money and fame but for fun.

A lot of the fun is gone in the little league. The continuing stress on winning at the lower age level is wrong. In order to win, you must use the little boys with talent and the burden falls on the gifted few. The giants of the court, of the diamond, of the gridiron, the giants of any sport didn't get that way sitting on the bench. In order to have a winner in little league, the naturally gifted are often pressured beyond their capacity.

Some coaches apply so much pressure on the boys to win, that they call every play. The quarterback is the director and he should not have every play sent in by the coach. A baseball pitcher can't have every pitch signaled to him by the manager; he works with his catcher. Boys must learn to get out of tight places in sports and acquire knowledge of many different situations. This cannot occur if the emphasis is always to win and they are not allowed to play the game by themselves.

The age to begin to play to win and to use the best boys is probably in the high school. Before that, everyone should learn the fundamentals. Every boy on the team should play in every game, not only when the team is 10 runs ahead.

All players should be taught conditioning and exercises and urged to participate in year-round physical condition. Games should be scheduled and scores kept but playoffs should be de-emphasized as should the giving of trophies and awards. The winning of a game is reward enough.

This is meant in no way to emphasize the winning of each game for its sake but is meant to build and emphasize the fundamentals of each sport and total participation for all boys. There are too many little boys contributing their bats and gloves, their sweat and tears (which come from sliding up and down the bench) to their teams.

With more boys participating in all athletic contests, more boys will have FUN in the participation of these events, learn the fundamentals, the intricacies of the games and subsequently many more will arrive at the high school and college level in better physical condition, better players, and with a better psychological attitude toward athletic contests in general.

Perhaps a lot of poor sports would be improved if they had more opportunity to be sports.

MYCETISM

William L. Smith

Montgomery, Alabama

Mushroom poisoning, or mycetism, is perhaps one of the rarest causes of morbidity and mortality in the state. Why, therefore, consider it? Because it exists; because the mushrooms are here. A change in the eating habits of a small segment of the population could cause the problem of Mycetism to present. Five patients with mushroom poisoning have recently been reported from California.[1] One died despite vigorous and intelligent treatment. The four survivors experienced severe illness and serious liver damage. The editor has received a letter from The National Registry of Deaths from Mycetism. Finally, the editor has made the study and gathering of mushrooms a minor hobby during the past several years.

More and more articles about mushrooms have been seen in the lay press. A magazine widely distributed to the Medical Profession carried an excellent article on mushrooms. They did, however, picture and describe Lepiota molybdites as edible. Our best knowledge classifies this species of Lepiota as poisonous. The newspapers carried an article about the psychotoxic or intoxicating effects of a mushroom found in Mexico. Food magazines have described the "fool proof four" of mushroom gathering. Adventure calls. Somewhere in Alabama improperly directed gathering of mushrooms for table may begin.

The vast majority of Americans do not gather wild mushrooms for eating. This is not true in many other parts of the world. There are records of this practice dating back thousands of years. The early Romans, for example, prized mushrooms as food. They studied them but not very scientifically. Much of their knowledge was based on folklore and superstition. This did not prevent the shrewder from using mushrooms as a means of assassination or power. One Pope is said to have died of Mycetism. Caesar ate a mushroom, identical in general characteristics, to the most deadly. He claimed indestructability thereby. The fungus is named for him, Amanita Caesarea.

Mushrooms are fungi. They grow on organic matter and without sunlight. They are cousins of Monelia, etc. They vary in size from microscopic to larger than a man's head. Some are good, some are bad, some are indifferent, but a few are very deadly. Most mushrooms have gills ("toad stools"), but some, notably the boletus and puffball, do not. Most mushrooms are edible, or at least not deadly. This brings up the two cases of euphoria and psychotoxic effects of mushrooms have some basis of credibility and sober observations.

Certain tribes of N. Central Asia were observed to achieve a state of "intoxication" after drinking the liquor in which a mushroom had been boiled. Almost the entire village was involved. The next day all villagers saved their urine. The winter having arrived, the urine was frozen. Thereafter, the thawed urine was drunk to produce similar intoxicating states. Then, the Mexican reports appeared in the lay press during the past few years. The natives were said to reach an euphoric state after the ingestion of a certain native mushroom. If memory serves, it was identified as a newly discovered species of Hyphaloma. Having found Hyphaloma in the back yard, we are still not excited.

It should be pointed out that the prolonged boiling of mushrooms changes their toxicity. This may account for the variance of reports concerning toxicity.

In this area there are only two mushrooms which appear in quantity and brilliance on the lawns, golf courses, and cemetery plots. They are either Lepiotas or Agaricas. The vast majority of the former will be Lepiota Molybdites (Morgania), the latter will be

1. Mushroom poisoning in five patients. (Amer. J. Med. 38: 787-792, 1965)

Agaricus Campesteres. Get under a tree and you are likely to find a rare one. Get in the truly wooded area and you find thousands of mushrooms of all colors and many shapes.

We found the greatest number of Amanita phalloides, in our casual search, in a heavily wooded area near Salisbury, North Carolina. Amanita Ceasarea was found on the shore of Lake Martin, Coosa County, Alabama. Amanita muscaria was found in Elmore County, (Ala). A rubescene, we have either not found or not recognized. We have not done microscopic examinations of the spores on any of them. We did find about fifty prime Coprinus comatus between the street and the sidewalk on South Court Street, Montgomery. We consumed them with gusto.

The Lepiota molybdites is more frequent in this area. Magnificent specimens, some measuring almost a foot across the cap, have been seen after a hard rain and a cool night. The young forms can fool the untrained.

The mushroom of the woods is another story.

Death due to Mycetism is reportable and classified under code E 879 (Accidental poisoning by noxious food stuffs). The only available statistics show ten deaths in Alabama classified under E 879 for 1962. We believe none of these was due to Mycetism. The letter mentioned earlier, however, should be quoted:

February 14, 1963

Editor:

Publication of the following note in your editorial pages will be appreciated:

The National Registry of Deaths from Mycetism maintains a file of deaths attributed to ingestion of wild mushrooms (1957 to date).

Physicians are requested to send notice of all such deaths (age, sex, date, locality) to the undersigned.

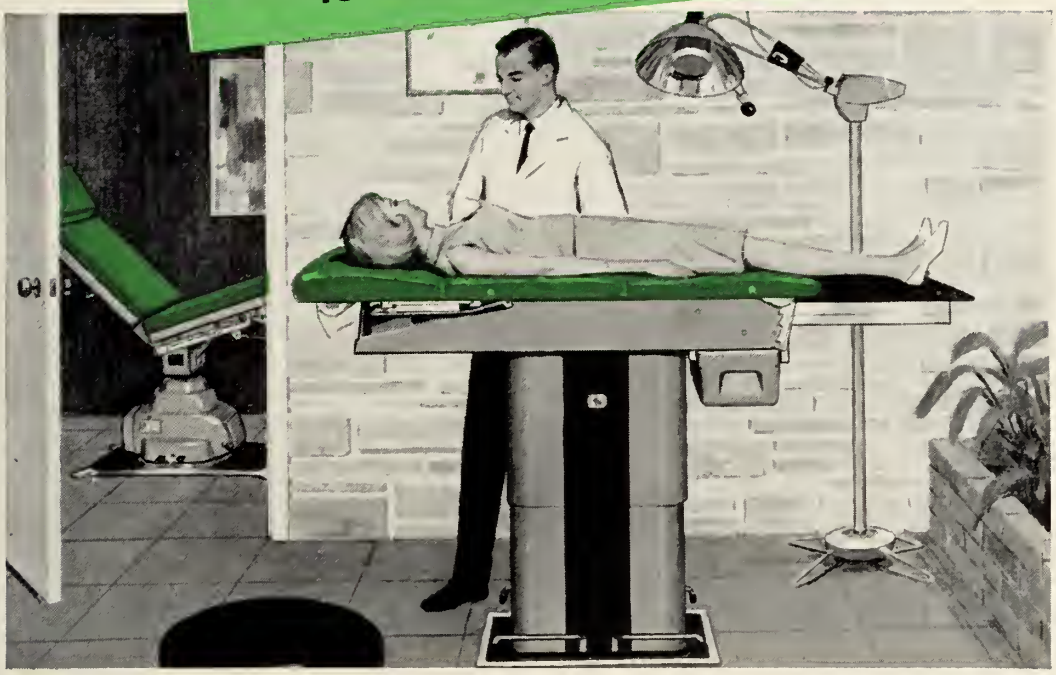
Robert W. Buck, M. D.
Secretary
Massachusetts Medical Society
22 The Fenway, Boston 15

Mycetism is usually given little notice in medical texts. There are two mushrooms responsible for perhaps all the fatal cases of Mycetism. The first is Amanita phalloides (the destroying angel) which contains a hepatical toxin, and second the Amanita muscaria, which contains muscarine. Some hours after the ingestion of even moderate quantities of Amanita phalloides there is severe abdominal pain, nausea, vomiting, and diarrhea. In a very few days there may be jaundice, anurea, and death from acute yellow atrophy of the liver. Treatment seems to be of little avail, except, however, that there has been reported the preparation of an antitoxic serum. The Pasteur Institute of Paris has prepared "Serum Antiphallinique" which is said to have saved the lives of some persons who otherwise would have died from the ingestion of Amanita phalloides. Ingestion of Amanita muscaria leads to a quite early development of signs and symptoms of muscarine poisoning. This is a sympathomimetic stimulation. There is nausea, vomiting, diarrhea, increased bronchial secretions, and bradycardia. Treatment consists of the administration of atropine and supported measures. Adequately treated cases may be expected to survive. In the case of poisoning with either species large doses of morphine may be required to relieve pain.

The ingestion of mushrooms of lesser toxicity produce symptoms resembling ordinary food poisoning, and unless a very large quantity has been ingested should not cause death.

After thousands of years man still writes about the same problems. Mushrooms have been eaten since the dawn of civilization. They make delightful food, they are composed primarily of nitrogenous substance and water. They are low in carbohydrate, and high in vitamins. Man will continue to eat them, but let him who chooses his own mushrooms, either be an authority or depend upon a good one.

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Anniston Medical and Surgical Seminars

Wednesday, November 17, 1965
1:00 p. m. to 4:30 p. m.
Reception and Dinner 5:00 p. m.

Anniston Country Club
Anniston, Alabama

1:00—Registration

2:00—Diverticulitis—James H. Johnston, M. D., F. A. C. S., Assoc. Clinical Professor of Surgery, Univ. Mississippi School of Medicine

2:30—Diagnosis and Office Treatment of Depression—Albert Bowen Stephens, Jr., M. D., Assistant Professor, Department of Psychiatry, Univ. of Alabama, Birmingham

3:00—Examination of Infants and Children—Ralph Victor Platou, M. D., Professor and Chairman, Dept. of Pediatrics, Tulane Univ. School of Medicine

3:30—Pulmonary Emboli—Beverly Woodlin Cobbs, Jr., M. D., Associate Professor of Medicine, Emory Univ. School of Medicine

4:00—Coffee Break: Exhibit of Intensive Care Unit—Flynn Robert, M. D., Assistant Chief, Coronary Section, Heart Disease Control Branch, United States Public Health Service

4:30—Panel

5:15—Reception

6:30—Dinner

Space Medicine—Col. Phillip G. Keil, M. D., F. A. C. P., Director—Bio-Astronautics Headquarters, Washington, D. C.

Sponsored by the Calhoun Medical Society

On September 16, 1965, the Alabama District Branch of the American Psychiatric Association held its first meeting of this year at Tuscaloosa, Alabama, in conjunction with the meeting of the Alabama Academy of Neurology and Psychiatry.

At the May, 1965, meeting of the American Psychiatric Association in New York, the Alabama District Branch of the American Psychiatric Association was officially approved. Membership in the District Branch is composed of physicians already members of the American Psychiatric Association, who are residents of Alabama. A group of psychiatrists in the State had been working for some time to form a District Branch. The following slate of officers was approved:

Charles E. Herlihy, M. D., Birmingham, President; LeRoy Lamm, M. D., Tuscaloosa, President-Elect; John D. Elmore, Birmingham, Secretary-Treasurer; James N. Sussex, M. D., Birmingham, Delegate to the Assembly of District Branches of the APA.

Three Counselors appointed were: Benjamin Morton, M. D., Birmingham; Joseph Barrett, M. D., Birmingham, and Fritz Kant, M. D., Birmingham.

The object of the District Branch shall be to foster the science and progress of psychiatry, in cooperation with, and as a constituent part of, the American Psychiatric Association, to serve as an influence toward the maintenance of high professional and administrative standards thereto related, and to assist the American Psychiatric Association in promoting its aim and objectives.



PATHOLOGY FORUM

The Antibody Screening Test, A Vital Prenatal Laboratory Study

CARLYN C. TUCKER, M. D.

AND

THOMAS A. NOTO, M. D.

The evolution of erythroblastosis or hemolytic disease of the newborn as a clinical entity received its initial impetus with the work of Diamond, Blackfan and Baty in 1932.[1] They related the previously known symptoms of icterus gravis, anemia neonatorum and hydrops fetalis to this condition. However, the etiology of this disease remained poorly understood until Levine, et al.[3] detected an antibody in the serum of a recently delivered woman. This latter finding was supported by the discovery of the Rh factor by Landsteiner and Wiener.[4] It is now well established that erythroblastosis fetalis is produced by the destruction of fetal erythrocytes by maternally produced antibody.

The first antibody to be incriminated in this disease was anti-Rho (D). This antibody is still the most common offender, producing more than 90 per cent of the cases of erythroblastosis fetalis. As our knowledge of this disease has increased, other antibodies have been described which are capable of producing hemolytic disease. Therefore, this pathologic condition may occur whenever there is a blood group difference of any kind between the mother and her child. For example, in cases of ABO incompatibility, immune anti-A and anti-B can cause destruction of fetal red blood cells; however, the end result in these cases is seldom serious. Other antibodies which can cause severe erythroblastosis fetalis belong to the MNS, P, Lutheran, Kell, Lewis, Duffy and Kidd blood group systems. In addition to these, antibodies to known rare antigens can occur also in pregnancy.[5] While antibodies to these minor blood groups account for less than ten per cent of the cases of erythroblastosis fetalis, any of them can produce severe hemolytic disease and death.

A recent case seen in the University Hospital Blood Bank illustrates the occurrence of

From the Department of Pathology, Medical College of Alabama and Clinical Laboratories, University of Alabama Hospitals and Clinics.

potentially dangerous atypical antibodies in obstetrical patients. The patient was admitted to the hospital for delivery of her third child by caesarean section. She had two previous sections and one spontaneous abortion. Blood transfusions were administered on two of these occasions. Prior to the caesarean section, a routine type and crossmatch was requested on the patient. She was typed as O, Rho (D) positive. During the crossmatch an incompatibility with type-specific blood was detected. As a result of this finding, an antibody screening procedure was done. The results of this test revealed a mixture of atypical antibodies. These were identified as anti-Kell (K), anti-Duffy^a (Fy^a) and anti-rh″ (E). The titer of each antibody was 1:128, 1:64 and 1:16 respectively. The infant, who was delivered in good condition, had a weakly positive direct anti-human globulin reaction (Coombs Test). The infant was typed as O, Rho (D) positive, Kell negative, rh″ (E) negative but Duffy^a (Fy^a) positive. While three antibodies were present in the maternal serum, only anti-Fy^a was eluted from the infant's red cells. This antibody was undoubtedly responsible for the positive direct anti-human globulin reaction. The infant did well clinically and never exhibited signs of a hemolytic process.

Immunization in this woman probably occurred as a result of her previous blood transfusions. (It should be noted that donor blood which is compatible on crossmatching may stimulate antibody formation in the recipient if minor blood group antigens are present in the donor blood but absent in the recipient's blood. It should be stressed that donor selection is based primarily on ABO and Rho (D) antigens. Therefore, a crossmatching test will not necessarily prevent immunization of the recipient.) The lack of clinical symptoms in the infant was related probably to the relatively low titer of anti-Duffy^a (Fy^a).

Serologic tests performed during the prenatal period have one ultimate purpose; that is, to determine whether or not an infant affected with hemolytic disease is to be expected. If the infant is affected, the results of these tests then serve to prognosticate the severity. Furthermore, the ready availability of this information permits:

1) Selection of compatible donor blood for the infant prior to delivery since in these instances maternal serum is used in the crossmatch.

2) Selection of compatible donor blood for the mother if she should require transfusions at or after the time of delivery.

3) Interruption of pregnancy so as to deliver a viable infant.

In addition to an ABO grouping and Rh genotyping, obstetrical patients should be examined for the presence of atypical antibodies. This is done in the clinical laboratory by the antibody screening test, a procedure wherein the patient's serum is added to selected group O red cells which contain all the known clinically significant blood group antigens. Since the incriminating antibodies in hemolytic disease are of the so called "incomplete" variety, the screening procedure should include the indirect anti-human globulin test performed with albumin suspended test cells. If an atypical antibody is detected in the screening procedure, then it can be identified and serologically quantitated.

It is recommended that these tests be performed during the first trimester of pregnancy. If this is not feasible, the antibody screening test should be performed during the 32-34 weeks of the gestational period.[6] During this period of the third trimester, chances for immunization are enhanced because the likelihood for transplacental passage of fetal erythrocytes is increased.[2]

The incidence of these potentially dangerous atypical antibodies will increase with certainty because of the widespread use of blood transfusions in women in the child bearing age. As a result, these antibodies will be encountered more frequently in hemolytic disease of the newborn. Thus, the importance of the antibody screening procedure for all obstetrical patients, including primigravidas, regardless of Rh blood type, becomes self evident. Extra attention, of course, should be

given to those patients who have received blood transfusions, a fact illustrated in the case presented.

Early diagnosis followed by exchange transfusion carried out promptly and skillfully are prime considerations in the proper management of infants with hemolytic disease.[7] Early diagnosis is possible only through the early detection of immunization during pregnancy. This can be achieved only by the proper utilization of antenatal blood studies which include routinely the antibody screening test. Today, with the increasing use of amniocentesis, the fetus can be observed carefully for the development of signs of hemolytic disease. This and other methods, still in the experimental stages, which are designed for the attenuation of symptoms due to hemolytic disease, stress the fact that early detection of antibodies in the maternal serum becomes a vital part of prenatal care.

References

1. Cohen, Flossie, Zuelzer, W. W., Gustafson, D. C. and Evans, M. M., "Mechanisms of isoimmunization. I. The transplacental passage of fetal erythrocytes in homospecific pregnancies", Blood, 23: 621, 1964.

2. Diamond, L. K., Blackfan, K. D., and Baty, J. M., "Erythroblastosis fetalis and its association with universal edema of fetus, icterus, gravis neonatorum and anemia of newborn," J. Ped., 1: 269, 1932.

3. Levine, P., and Stetson, R. E., "Unusual cases of intra-group agglutination," J. A. M. A. 113: 126, 1939.

4. Landsteiner, K., and Wiener, A. S., "Agglutinable factor in human blood recognized by immune sera for rhesus blood," Proc. Soc. Exp. Biol. and Med. 43: 223, 1940.

5. Mollison, P. L., Blood Transfusion in Clinical Medicine. 3rd Edition, 1961.

6. Thompson, P. R., Manual for Workshop on Hemolytic Disease of Newborn, American Society of Clinical Pathologists. Commission on Continuing Education. 1964.

7. Walker, W., "Management of haemolytic disease of the newborn," British Med. Bull., 15: 123, 1959.

MID-YEAR MEETING

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Lomotil is not known to inhibit nonpropulsive intestinal movements.

Roentgenograms demonstrate that this activity occurs within two hours after oral administration and persists for at least six hours.

Comparative studies in the rat show Lomotil to be more effective in inhibiting fecal excretion than either codeine or morphine.

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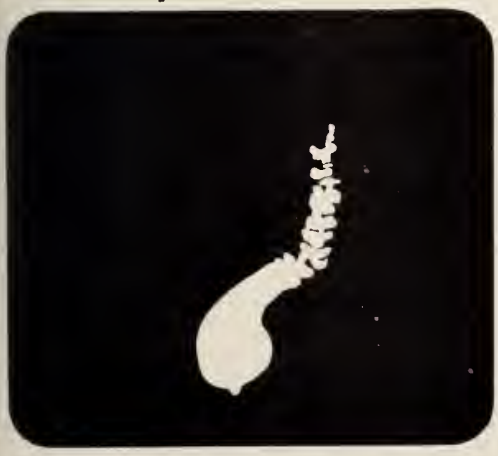
slows propulsion



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Precautions: Lomotil is an exempt narcotic preparation of very low addictive potential: more than three million prescriptions have now been written for Lomotil. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, *given in divided doses,* until diarrhea is controlled, are:

Children:

3 to 6 months—3 mg. (½ tsp.* t.i.d.)
6 to 12 months—4 mg. (½ tsp. q.i.d.)
1 to 2 years—5 mg. (½ tsp. 5 times daily)
2 to 5 years—6 mg. (1 tsp. t.i.d.)
5 to 8 years—8 mg. (1 tsp. q.i.d.)
8 to 12 years—10 mg. (1 tsp. 5 times daily)

Adults:

20 mg. (2 tsp. 5 times daily or
2 tablets 4 times daily)

**Based on 4 cc. per teaspoonful.*

Maintenance dosage may be as low as one fourth the therapeutic dose.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE *Research in the Service of Medicine*



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There is a gentle stirring within the breast of Alabama medicine.

It's not a full-blown throbbing yet; rather it is more in the nature of a first fetal heartbeat.

The cause of the action stems from a surge of hope which arose in the closing hours of the 1965 Regular Session of the Alabama Legislature.

The bitter taste of defeat after passage of the Medicare bill by the U. S. Congress was diluted and sweetened by numerous significant victories in the Alabama Legislature.

One by one, during the long hot days of late Spring and Summer, objectives undreamed of a year ago were achieved. Already to medicine's credit was a generously-endowed Medical Scholarship law enacted by the Special Session of the Legislature without one single dissenting vote in either House or Senate.

Immediately upon convening of the Regular Session in April, acting upon a program adopted at the 1965 annual session of the Medical Association of the State of Alabama, new requests were placed before state officials and the Legislature.

The State Health Department, on the opening day, sponsored a bill in the Legislature to remove unrealistic salary ceilings on professional categories to make possible employment of qualified workers in numerous key positions.

Simultaneously, the Governor was asked to increase the Department's appropriations for the biennium 1965-1967 by a minimum of four million dollars. Both programs had unanimous endorsement of MASA.

While the Governor was unable to increase Health Department appropriations a full two million dollars per year (his best effort netted only slightly more than $500,000), he did lend the full weight of his Administration to a plan to increase the cigarette tax by one cent per package. The levy actually will net slightly more than the Health Department originally sought.

With these two key measures enacted into law in the closing hours of the Legislature, physicians of Alabama have experienced a rebirth in morale. The attitudes of the individual legislators, almost without exception, have demonstrated that our elected lawmakers do have a genuine concern for the health of the citizens of this state and that they will not stint financially when the situation is fully explained to them.

Partisan politics fell by the wayside as Medicine's program of preventive medicine came up for consideration. Administration and anti-administration legislators combined to enact the necessary laws with a minimum of delay. In those infrequent instances when compromise became the order of the day there was ample evidence that political expedience did not necessarily jeopardize the health of the people.

For generations to come Alabamians will owe a debt of gratitude to those legislators who devoted their abilities and energies so generously to the cause of health. And to those physicians who virtually abandoned their practices during the legislative period to clinch passage of the bills, this profession should have only praise.

Countless telephone calls, telegrams and letters emanated from those dedicated physicians, directed toward both the U. S. Congress and to the State Capitol in Alabama. These efforts achieved a great victory and not, ironically, for glory or the financial reward of those who waged the fight but for a multitude back home who probably didn't even know a fight was in progress.

ELECTRONIC DATA PROCESSING AND THE COMPUTER

Electronic Data Processing and the Computer are coming to the aid of the physician and dentist. Billing and bookkeeping services are being offered by banks and computer service companies that assist you in the business side of your practice. Physicians and dentists are finding this system not only frees them and their nurses from non-medical routine, but that it provides accurate daily records and gives them precise controls. Consequently, practices are conducted more profitably. Generally billing and bookkeeping costs are cut; you have up-to-the-minute financial information. Accounts receivable collections are stepped up considerably and the medical aide or clerk is relieved of a time-consuming chore so she can be of greater service in the practice. Systems, such as Medac System, Inc., which was developed especially for physicians and dentists by a CPA and attorney, long skilled in doctor services, offer a wide range of services:

1. A complete computerized double entry bookkeeping system.

2. Patient billing service.

3. Daily cash receipts and Charges Report from the computer.

4. Monthly Accounts Receivable Report aged to over 120 days.

5. Report of types of services performed and income from each.

6. Patient visit and payment record mailed at end of the year for their income tax records.

7. Cash Disbursement Reports from the computer.

8. A profit and loss statement at regular intervals if desired.

9. A statement of Assets and Liabilities at regular intervals if desired.

10. Computation of quarterly income tax.

11. Patient payment reminders if desired.

12. Next visit reminders on monthly statement or separate.

13. Collection service.

An article in *Medical Economics*, August, 1965, entitled "What M. D.s Think of Computer Services" provides an unbiased analysis of these services.

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OCTOBER

Symposium on COMMON PROBLEMS IN GENERAL PRACTICE—OFFICE PROCEDURES. Mound Park Hospital Foundation, Florida Academy of General Practice—(16th Annual Scientific Assembly)—October 29 and 30, 1965—registration 12:00 to 5:00 P. M., October 28th. The Foundation reserves the right to limit registration. By special arrangement—NO REGISTRATION FEE. 14 Accredited Hours by the American Academy of General Practice. Address—GENERAL PRACTICE, Mound Park Hospital Foundation, Inc., St. Petersburg, Florida 33701.



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Hypersensitivity, and most cases of severe renal or hepatic disease.
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Side Effects
Constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, leukopenia, muscle cramps, nausea, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage
One tablet (100 mg.) daily with breakfast.
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Guest Editorial....

MEDITATIONS ON MEDIATION

Arthur I. Chenoweth, M. D.

Birmingham, Alabama

"He would have been known to the world as a Patriot, had he not been known as something greater—a Physician."

To read this tribute to our profession must, if we are sensitive, give us a sense of humility. The tribute was written very soon after the turn of the century.

Now let me go on to present time.

"All too often the modern doctor is viewed by his patient as an abrupt and harried business man, impersonal, and not as the warm and faithful doctor, ever available in the time of illness, anxiety and stress - - - -."

And another by a friend of medicine, a sort of an apology, "- - Perhaps they won't make house calls, due to being busy with golf on week-ends, but - - - -".

These remarks were made in 1965.

Why has the image changed? The question is not easily answered, for, in the first place the second picture of the doctor is no more accurate than the first. It is, I think, simply that the lay public is just beginning to realize that we, too, have feet of clay. Like Ulysses, "I am a part of all that I have met." Just so we are a part of the very complex society which we attempt to serve. We see those about us enjoying the material blessings of this very affluent society; we are aware of the eight-hour day, the five-day week, the long week-end, the time-and-a-half for overtime—and we think, "Why not?"

Why not, indeed! The truth is that we had a choice and, having chosen a career of service, we must stick with it. For the most part we do stick with it, and as a consequence, pursue our labors and earn our rewards of satisfaction in work well done. In addition, we do have a higher income, some nights and occasional week-ends of freedom, and are on the whole a good deal more in touch with those about us than were our colleagues of earlier years.

Serving for several years as a member of the Mediation and Medical Ethics Committee of my County Society has been for me both a privilege and a burden. The position is both rewarding and frustrating, but at all times, interesting. The Committee provides a vantage point from which both the physician and his patients can be regarded with a fair degree of objectivity. Observation from this vantage point leads to certain definite conclusions: (1) The physician as an individual is held in warm regard and high esteem by the vast majority of patients and families of patients. (2) The vast majority of the physicians justly merit this affection and esteem. (3) Exceptions are to be found in each category. It is upon these exceptions that we may dwell for a few minutes, and thus attempt to summarize some common causes for criticism of the medical profession:

Financial problems: There are many complaints about charges. Most of these could be avoided if the doctor would take the time, before examining, treating or billing the patient, to discuss with him the proposed

(Continued on Page 285)



TUBERCULIN, TINE TEST

(Rosenthal) Lederle

ideally suited for routine screening

accurate—comparable to the older standard intradermal tests

practical—can be administered by nurses under physician supervision

convenient—no refrigeration or other storage precautions

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Side effects are possible but very rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis. *Available* as the new individually-capped unit, boxes of 5, or in cartons of 25.

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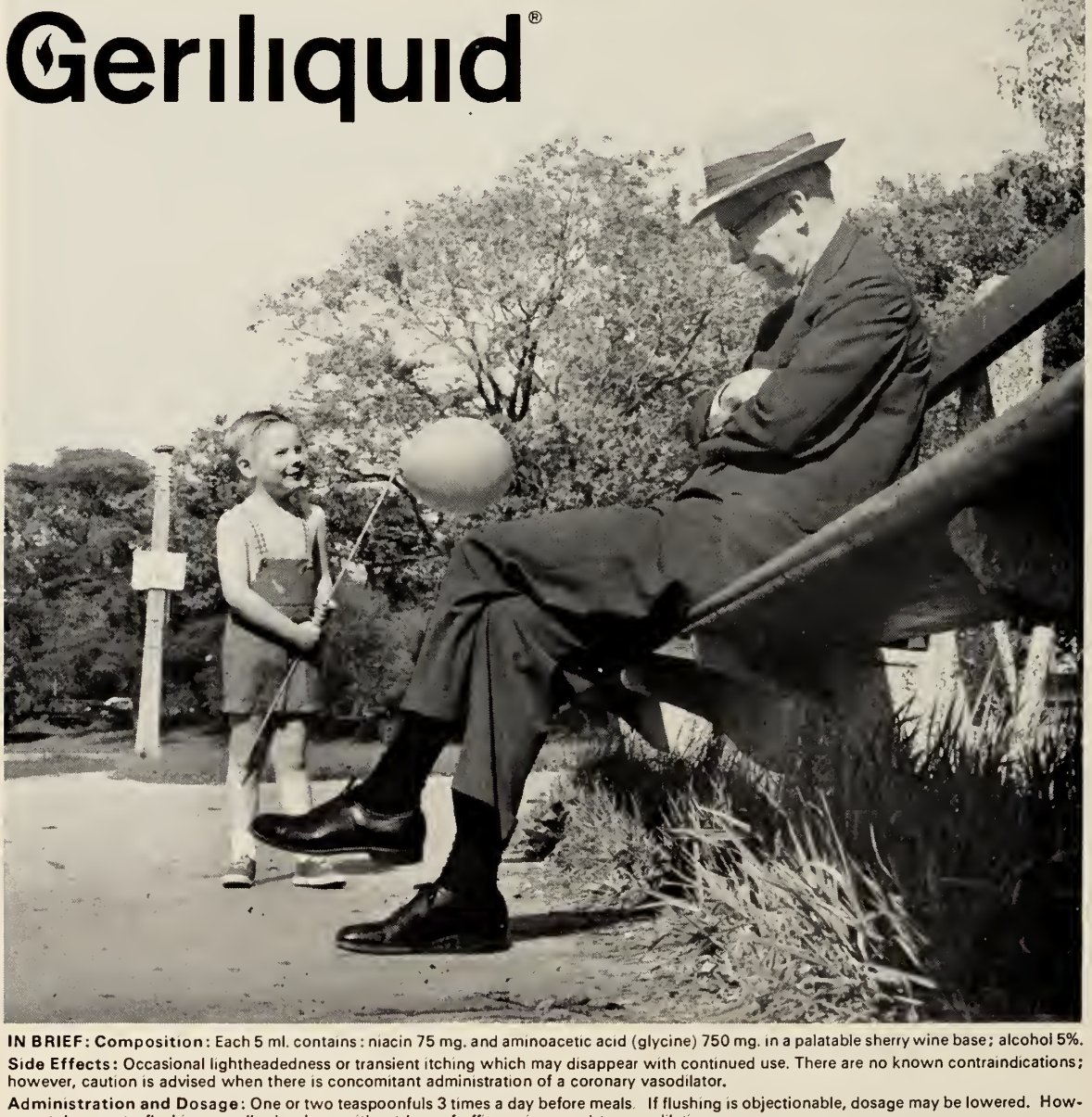
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when even southern sun fails to warm cold hands and feet

provide rapid, sustained vasodilation for warmth and relief of pain, dizziness and faintness in patients with impaired peripheral circulation

GERILIQUID warms cold hands and feet through the thermogenic action of glycine and through sustained vasodilation by glycine and niacin. In addition, in patients with impaired peripheral circulation, GERILIQUID increases the ability to walk farther with less pain. Patients particularly like the palatable, sherry wine base.

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IN BRIEF: Composition: Each 5 ml. contains: niacin 75 mg. and aminoacetic acid (glycine) 750 mg. in a palatable sherry wine base; alcohol 5%.

Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.

Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.

Supplied: Bottles of 8 oz. and 16 oz.

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(Continued from Page 282)

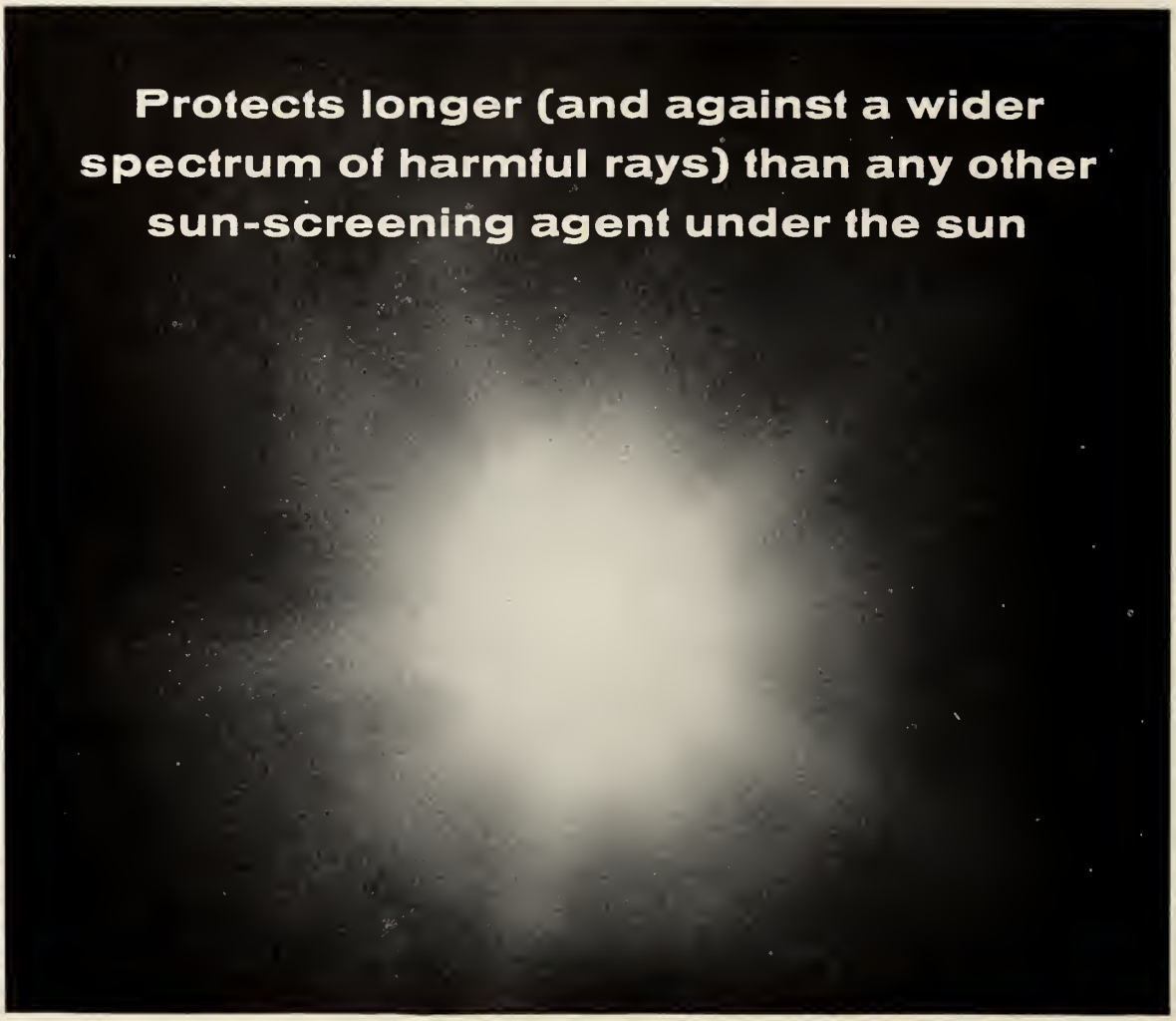
charges. Most patients understand the cost of X-rays and laboratory work, and are willing to meet any bill which they understand. The cost of a doctor's time is somewhat harder to comprehend. All in all, it is thoroughly worth while to spend a few minutes discussing costs—early in the course of management. On the other hand, if a complaint has been registered by a patient after receipt of a bill, even then an amicable agreement can be reached, provided the patient is allowed to present his complaints to the doctor himself. All too often the patient's protests are brusquely brushed aside with "I don't discuss fees; they are up to my bookkeeper"; or "If you have an objection talk to my secretary." For the most part, medical fees are just and realistic. Moreover, most physicians are eager to correct a hardship imposed upon a patient. A typical note from a co-operative and conscientious physician brought immediate payment of the amount originally stated. "If the balance due is not fair in your opinion, or if it will work a hardship on you, please let me know and I will be glad to make an adjustment in these charges." On the other hand, there are rare individual physicians who do make charges well above the average charges for similar work in the community, and who take the position that this is no one else's business. The fact is that circumstances of medical economics today do make physicians' fees the concern of the physician, the patient, —and an insurance company! Like rising taxes, and certain social changes, we have to adjust to this fact of life! It is true that most insurance companies will adjust their allowances if a physician is willing to discuss the case and explain his position.

Failures in communication: This category embraces many situations but they have a common origin—failure of the doctor to spend enough time with the patient to: (a) explain a proposed plan of treatment and the results to be expected, (b) give a report to the family anxiously waiting outside the treatment or operating room, (c) inform the patient of an unexpected development, (d) tell the patient in advance if he, the physician, is to be unavailable for a day, a week-end or a week. If a partner or other colleague is to serve as a substitute, he should be introduced either by name or in person. Of course, this takes time, but is certainly time well spent; for it is one way in which we retain the personal touch while still enjoying the benefits of partnership practice.

Loss of composure: Today's physician is on the run most of the time, whether day or night—usually to attend a committee meeting or to get to the record room—if not to attend a patient. As a consequence, he is apt to be, or at least to seem, impatient, brusque, or rude. When under these conditions he is harassed by an unreasonable patient he is likely to lose his composure, if not his temper. To do so, is to lose at the same time his dignity, and the respect of the patient or his family. It must be admitted that many barbs and stings must be suffered, many unreasonable requests answered, and many unanswerable questions parried. If firmness and patience wear thin, it is always possible with dignity and a furrowed brow to usher the patient along the hall while saying, "I believe that I shall look up that matter!"—and then reach for a tranquilizer! Most patients respond to the quiet manner and reassuring word.

Indeed, if we do no more for our patients than bring them kindness, sympathy, understanding and an attentive ear, we can avoid about 95 per cent of the problems which come to the attention of the mediation committees.

It is of paramount importance, and perhaps one of our prime functions always "to carry on our tongues gentle peace, to quiet troubled hearts." If we do so, we shall, I think, justify our heritage as reflected in the words of Robert Louis Stevenson, "There are men and classes of men that stand above the common herd: the soldier, the sailor and the shepherd not infrequently; the artist rarely; rarer still the clergyman; the physician almost as a rule."



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ULTRA-VIOLET ABSORBING LOTION*

Clinical studies show that many drug-induced photosensitivities are initiated by solar rays longer than 3200 Å. Most commercial lotions absorb *only short, burning rays up to about 3100 Å.* New UVAL provides excellent screening of short, erythema-causing waves *and* sustains high effectiveness throughout the photosensitizing spectrum (up to 6500 Å). Moreover, laboratory studies in humans demonstrate that UVAL protects *hours longer‡* than any other sun-screening agent available. Such protection is unprecedented. UVAL has no known contraindications and is cosmetically acceptable. Literature (including a list of photosensitizing agents) and samples available on request.

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The discomforts of

DIARRHEA
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. . . are relieved by direct musculotropic action with

Trocinate®

BRAND THIPHENAMIL HCl

Available in 100 milligram pink sugar-coated tablets.

The high therapeutic index permits dosage sufficient to relieve spasm promptly. The usual initial dose is 4 tablets. Maintenance dosage is usually one or two tablets 4 times a day.

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BETA-DIETHYLAMINOETHYL DIPHENYLTHIOACETATE HYDROCHLORIDE

. . . directly relaxes smooth muscle spasm
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Trocinate (Thiphenamil HCl) has been found in three clinical studies, (J. Mo. Med. Assoc., 48:685-6; Med. Rec. & Annals, 43:1104-6; J. Urol., 73:487-93), to be effective and to be free of side-effects. Fifteen years of wide clinical usage has affirmed the safety and effectiveness of Trocinate.

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Manufacturers of ethical pharmaceuticals since 1856

1965 Medical Scholarship Awards Loans Listed

Fifty-Seven Medical College of Alabama students have been designated recipients of the 1965 Scholarship loans by the State of Alabama Board of Medical Scholarship Awards. Recipients are:

Freshmen

NAME	HOME TOWN	COUNTY
1. Charles Conner (4-year)	Highland Home	Crenshaw
2. Roddy Cook (4-year)	Dothan	Houston
3. William Edge (4-year)	Jasper	Walker
4. Ronald Hilyer (4-year)	East Tallassee	Tallapoosa
5. Eddie Lamon (4-year)	Muscle Shoals	Colbert
6. Milton Lennicx (4-year)	Robertsdale	Baldwin
7. Franklin Long (4-year)	Canoe	Escambia
8. Marilyn McRae (4-year)	Montgomery	Montgomery
9. Ronald Olivet (4-year)	Tuscaloosa	Tuscaloosa
10. Milton Raines (4-year)	Tuskegee	Macon
11. Martin Stallings (4-year)	Hartford	Geneva
12. Horace Thompson (4-year)	Bynum	Calhoun
13. William Walley (4-year)	Guntersville	Marshall
1. Howard Harper (1-year)	Mobile	Mobile
2. Bobby Holt (1-year)	Remlap	Blount
3. Dewey Jones (1-year)	Adger	Jefferson
4. John Marshall (1-year)	Mobile	Mobile
5. Philip Newton (1-year)	Mobile	Mobile

Sophomores

1. Robert Bentley (3-year)	Columbiana	Shelby
2. Kirby Bland (3-year)	Abbeville	Henry
3. Kenneth Copeland*	Gadsden	Etowah
4. Wayne Coxwell*	Jackson	Clarke
5. Lawrence Farris*	Elba	Coffee
6. Harold Gebhart (3-year)	Foley	Baldwin
7. John Jeffers*	Auburn	Lee
8. Gillis Payne*	Greensboro	Hale
9. Elliott Monroe*	Clanton	Chilton
10. Harry Prim (3-year)	Dothan	Houston
11. Perry Savage (3-year)	Piedmont	Calhoun
12. J. Terrell Spencer (3-year)	Birmingham	Jefferson
13. William Watson (3-year)	Brundidge	Pike
1. William Hansford (1-year)	Andalusia	Covington
2. Robert Mathews (1-year)	Mobile	Mobile
3. Cocoran Sneed (1-year)	Montevallo	Shelby
4. George Thomas (1-year)	Birmingham	Jefferson

Juniors

1. James Austin (2-year)	Wetumpka	Elmore
2. John Blythe*	Alexander City	Tallapoosa
3. W. Pearson Clack*	Roanoke	Randolph
4. Gerald Cochran (2-year)	Crossville	DeKalb
5. L. Jan Davis (2-year)	Huntsville	Madison
6. Robert E. Hill*	Alpine	Talladega
7. Lennox Larrimore*	Dickinson	Clarke
8. James C. Matthews*	Silas	Choctaw
9. Knut E. Mueller*	Foley	Baldwin
10. T. Gerald New*	Wedowee	Randolph
11. Bruce Russell*	Cordova	Walker
12. Lee Taylor*	Sheffield	Colbert
13. Barry Wilson (2-year)	Wedowee	Randolph
1. Charles Burton (1-year)	Town Creek	Lawrence

Seniors

1. Jerry Dillard*	Hartford	Geneva
2. W. Rodgers Green*	Mt. Vernon	Mobile
3. Thomas M. Harris*	Montgomery	Montgomery
4. Louis Letson, Jr.*	Scottsboro	Jackson
5. David Marley, Jr.*	Brundidge	Pike
6. Martin D. Palmer*	Birmingham	Jefferson
7. William Stonecypher*	Cullman	Cullman
8. W. Carey Wallace*	Sylacauga	Talladega

*Previous holders of scholarship loans under the old law, which were automatically renewed.

The following have been awarded Merit Scholarships:

Freshmen

William Anderson Hill	Winfield	Marion
Terry B. Cooper	Gadsden	Etowah

Sophomores

Charles B. Dahlke	Aliceville	Pickens
James S. Sullivan	Northport	Tuscaloosa

Juniors

William T. Branch	Montgomery	Montgomery
Bonnie Maloy	Bessemer	Jefferson

Seniors

Reeves McLeod	Pensacola, Florida	
Michael Straughn	Repton	Conecuh

WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: **ACTIONS AND USES:** A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

in iron deficiency anemia for rapid and predictable replacement of iron reserves

imferon®

(iron dextran injection)



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to help relieve pain
in common
anorectal disorders

"non-caine"
Diothane®

Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form... both are now available.

DIOTHANE OINTMENT

COMPOSITION:
diperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:
Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.





DIOTHANE SUPPOSITORIES

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

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PHYSICIAN PLACEMENT SERVICE

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. Further information is available from the central office, 19 South Jackson Street, Montgomery, Alabama 36104— or Phone 263-6441.

LOCATIONS WANTED

General Practitioner with Anesthesiology, age 27, Protestant, Univ. of Pa. 1963, desires location solo or associate. Available immediately. LW-1

General Practitioner, age 33, Protestant, Tulane University 1963. Licensed Kentucky and Louisiana. Desires solo, group, or associate practice in Alabama. LW-2

General Practitioner, age 33, Protestant, University of Tennessee 1963. Lic. Mississippi. Completed military obligation. Small town desired. LW-3

General Practitioner, age 31, Univ. of Tenn. 1961. Lic. Mississippi and W. Va. Central section of state preferred. Completed military obligation. LW-4

General Practice with Surgery, age 35, Protestant, Medical College of S. Carolina 1955. Fellow Am. Soc. of Abdominal Surgeons. Military service completed. LW-5

General Practitioner with Surgery, age 48, Baptist. Tulane Univ. 1942. Seeking location as associate, industrial or instit. Native Alabamian desires to return to state. Completed military obligation. LW-6

Internist, age 34, Protestant, Medical Coll. of Ala. 1956. Certified Am. Boards Int. Med. and Cardiology. Desires group or instit. Completing AF duty. Available July 1966. LW-10

Pathologist, age 32, Catholic, Hahnemann Med. Col. 1959. Certified Am. Boards. Available 1966. Married. Completing two year obligation. LW-11

Urologist, age 33, Protestant, Univ. of Virginia, 1960; Desires location for solo, group, or associate. Available immediately. LW-12

Radiologist, age 28, Med. Col. of Ala. 1960. Protestant. Certified Am. Boards. Seeking location to fulfill state scholarship requirements. Available immediately. LW-13

PHYSICIANS WANTED

GP-INTERNIST-OB-Gyn or Surgeon needed as assistant in central Alabama town of 10,000+ pop. Experience in either specialty desired. Two hospitals (100-bed and 36-bed). Share fully equipped office. Excellent schools, many churches, near extensive lake area. Economic situation excellent. PW-1

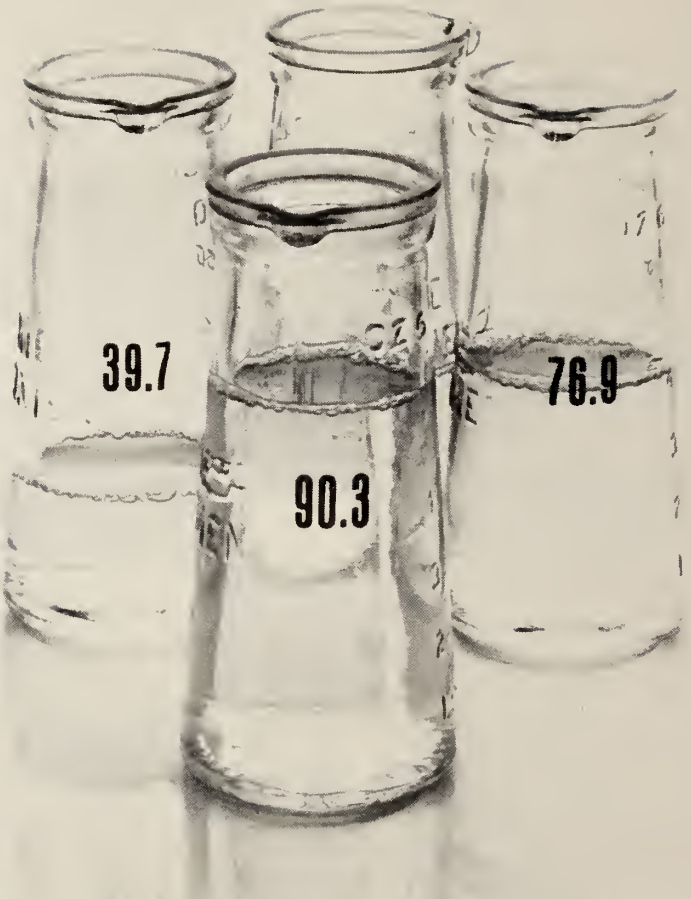
General Practitioner wanted for town in NE part of state. Pop. 3,630. Three miles of larger city with two hospitals of 292 and 60 beds. Staff privileges open. Fine cultural center, fast-growing industrial area; Modern air-cond. office completely equipped for rent or purchase. PW-2

Gen. Pract. with Surgery—SW part of state, 90 miles from Gulf of Mexico. Pop. 4,000, trade area 17,000. County hospital with 35 beds. Fully equipped clinic. Schools, churches and social activities excellent, in mild climate. PW-3

GP, Internists, Obstet. needed for mining areas of Alabama. Fringe benefits, salaried positions, either full-time or part-time. Younger men would find good economic opportunity. Older men welcome shorter hours. PW-4

General Practitioner wanted in SE town of 1,000 30 miles from Fla. line. Within 250 miles of market and traffic centers of the south. On Chattahoochee River waterways. Four new dams contribute to the town's economic status which derives income from industries, state docks, agriculture and timber. Town desires two physicians to meet the need. PW-5

General Practitioner for town in north central part of state. Pop. 1,300. Two hospitals located in county nearby and offer membership on staff. Near Birmingham with its specialized medical services. Modern clinic available, fully equipped. Principal sources of income mining, manuf., textiles, agriculture and city commuters. Six churches, exc. schools and social activities. Higher educational advantages nearby colleges. PW-6



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METAHYDRIN®

(trichlormethiazide)

To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin® (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.



If the dealer, North, is 46 yrs. old and West is 42 and East is 39 and South is pregnant, who has biliary dysfunction?

They're all vulnerable.

Patients approaching middle age, as well as pregnant women who complain of "irregular" constipation, belching, flatulence and indigestion with no evidence of organic disease may be suffering from functional disturbances of the biliary tract.

These basic disturbances can often be corrected by a single convenient and effective medication: Neocholan.

Neocholan is more than a laxative. It combines all the ingredients for the total management of functional biliary stasis in one tablet. Dehydrocholic acid stimulates the production of thin, free-flowing bile. Bile salts promote better digestion to absorb fats and fat-soluble vitamins, and they tend to prevent chronic constipation by maintaining intestinal tone and normal peristalsis. Phenobarbital and homatropine methyl bromide relax intestinal spasm and insure unobstructed passage of bile and pancreatic juice into the duodenum.

Neocholan is contraindicated in patients with glaucoma. Use cautiously in elderly patients with urinary retention and reduce dosage if blurring of vision, increase in pulse rate, or distressing dryness of the mouth result.

Each tablet contains Dehydrocholic Acid: 250 mg. (3¾ gr.); Bile Extract (Porcine): 15 mg. (¼ gr.); Phenobarbital: 8.0 mg. (⅛ gr.) (Warning: May be habit forming.); Homatropine methyl bromide: 1.2 mg. (1/50 gr.).

Neocholan®

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana

DOW



Lirugen™

is *truly* a one shot measles vaccine.

Lirugen is the most highly attenuated, but fully antigenic, live measles vaccine (Schwarz Strain).[1-8] Additional special passages of the Edmonston Strain resulted in further attenuation which reduces systemic reactions so effectively that the use of gamma globulin with Lirugen is not needed. In recent clinical trials, Lirugen was administered without gamma globulin to approximately 13,000 children. In 1,405 of these children tested serologically, a conversion rate of 99% was reported. Close medical follow-up of inoculated children and controls showed no significant differences between mean maximum temperatures in the two groups. The incidence of high fever (103°F and above, rectally) attributable to the vaccine could be calculated at less than 1%, and the occurrence of mild, transient rash at less than 3%.

Contraindications: Pregnancy; leukemia, lymphoma and other generalized malignancies; brain damage in children under one year of age; febrile illness; allergy to egg proteins, neomycin, or streptomycin. Precautions: Use cautiously in patients with a history of tuberculosis and patients being treated with steroids, irradiation, alkylating agents, and antimetabolites. Consult package literature before administering Lirugen.

References:

1. Schwarz, A.J.F.: Amer. J. Dis. Child., **103:** 386-389, 1962.
2. Krugman, S. et al.: Pediatrics, **31:** 919-928, 1962.
3. Andelman, S. L. et al.: J.A.M.A., **184:** 721-723, 1963.
4. Measles Vaccines: W.H.O. Technical Report Series No. 263, 1963.
5. Schwarz, A.J.F.: Annales Paediatrici, **202:** 241-253, 1964.
6. Morley, D. C. et al.: Bull. W.H.O., **30:** 733-739, 1964.
7. Andelman, S. L. et al.: Scientific exhibit at annual meeting of The American Academy of Pediatrics, 1964.
8. Krugman, S. et al.: J. Pediatrics, **66:** 471-488, 1965.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, U.S.A. Dow

Alabama Department of Public Health

A LETTER OF APPRECIATION

To the Physicians of Alabama:

I want to express my sincere appreciation for your individual and collective support during the 1965 legislative year. With your help we have reached milestones in public health such as have not been seen in the past thirty years. Legislation passed during this session will make possible new developments and services.

The advances made in public health during this legislative year will return the Alabama Department of Public Health from the brink of bankruptcy. Alabama has been 44th in the nation in public health expenditures with a per capita expenditure of 11½ cents from the state and $1.29 from combined local, state and federal sources. Only six states in the nation were doing less to protect the health of its citizens. An increased per capita health expenditure will result from the additional $1.8 million income anticipated from the one-cent tax on cigarettes.

More money will be available for badly needed indigent cancer services. A total of 547 new patients were approved for the cancer program in 1964, and 400 patients were turned down. Of those not approved, 221 patients were eligible for clinic services in every way. These could have been approved for services if money had been available.

Extensive retrenchment in laboratory activities became necessary in 1964 as a result of the reduction of U. S. Public Health Service general health funds. Support for Branch Laboratories in Selma, Huntsville and Dothan was stopped, Selma Lab closed, and some procedures of the central laboratory were discontinued. The laboratories can renew operation now that funds have been made available.

The increase in revenue will allow us to fill personnel vacancies at the state and county levels. The number of county employees has for some time been grossly inadequate to carry on essential services. The state has been without a director of nursing services for more than a year. One man is responsible for vector control throughout the entire state. There is no biostatistician to help us pinpoint our problems. There is an average of only one nurse per 12,000-13,000 population although the nationally accepted ratio for a traditional public health nursing service is one nurse per 5,000 population. There is an acute shortage of sanitary engineers. Strong consultant services from the state level are a must if the local health centers are to be strong.

Included above are only a few of the imminent needs and plans in Alabama health activities. Others are equally pressing and must also receive attention later this year.

Removing the ceiling on professional salaries in the health department is a vital advancement. This legislation allows a salary scale increase for the hiring of public health physicians and other professional personnel. The need for this law is exemplified by the fact that we start with 21 health officers

serving 67 counties. Adequate medical personnel to direct health department programs are essential if service is to be effective.

Other legislation passed this session affecting health is the new anti-pollution law. The most important change in the new law is the removal of a "grandfather clause" that exempted industries in existence prior to 1949 from compliance with water pollution control regulations of the Alabama Water Improvement Commission. The "grandfather" industries are given up to seven years to clean up the waste they dump into streams.

Another bill passed during this session requires all infants born in Alabama to be tested for phenylketonuria. This was initiated and passed without assistance from us. This service was begun last year and gained statewide acceptance on a voluntary basis. Also passed during the session was a law that foreign-trained physicians at the Medical College may be given a restricted license permitting them to treat patients within the confines of the University setting. An advisory council to the State Board of Health concerning the construction of medical facilities was provided by a new statute. H. B. 9 passed providing for a board to license physical therapists in Alabama. Prenuptial health certificates on marriage licenses no longer must be permanently attached with the passage of H. B. 1075. In all there were approximately 60 bills in the House and 30 in the Senate of some interest to the health department and physicians.

Speaking for public health workers and the people of Alabama, I extend our gratitude to each one of you who assisted us in preventing the collapse of public health services in Alabama. From the inception of the State Board of Health in 1875, physicians involved in the private practice of curative medicine have been concerned and charged with a unique responsibility for public health. In this legislative session you quickly accepted the responsibility to make certain that the lives and health of Alabamians would not be jeopardized by a failing preventative medical program. We appreciate each physician, each county medical society, and the State Board of Health as a group for calling on your state senators and representatives to enact house bills 874 and 53. It is support such as this that promises to return Alabama to a position which will again lead the nation in public health and preventive medicine. With private physicians rallying to our support as you have done, the wishes of organized medicine are respected and the public benefits by your advice and interest.

Thanks for your continued interest and support.

Ira L. Myers, M. D.
State Health Officer



"You're the sixth case of trading stamp tongue this week!"

Reprinted from: "The New Physician"

the price of "success"

190/102

Hypertension has been called the price of success... and in some life-situations, the cost of failure. In either event, Metatensin lowers blood pressure, cushions the patient against stress and retards the progress of disease. Metatensin is effective and economical. It is well-tolerated over long periods.

THERAPY
YOU CAN STAY
WITH

METATENSIN®

EACH SCORED TABLET CONTAINS:
Metahydrin® (trichlormethiazide) 2 mg. or 4 mg. Reserpine 0.1 mg.

In Brief: Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery. Contraindications are complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.
Supplied: Metatensin tablets, 2 mg., 4 mg. — bottles of 100 and 1000.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

The Woman's Auxiliary



Few of us are leaders of high competence, but each one has a potential for growth and development, especially if she will take advantage of high caliber leadership and stretch the resources of mind and heart.

The purpose of life is to MATTER. Dr. Albert Schweitzer noted simply that he who sought to serve found the meaning of life. Unless we give ourselves, we fall short of making our best contribution.

Women are assuming an increasing role in citizenship affairs today. Our evolving civilization has brought the woman to a new place in society, and her contributions are significant. Her power can be a deciding factor in the future of America. She is aware, she is concerned, she is compassionate, and she is prepared as never before. She is making her mark in the home, in business, in the professions, in government and in politics.

"She has not liked what has been going on in the world these past few years," editorialized the Saturday Evening Post not long ago. "She has worried about peace and schools and delinquency and the moral tone of our society. She has the time and brains to tackle these problems. We need to use her, thankfully, because she has brains, time, knowledge, courage, sensitivity and dedication that are needed in our struggle for survival."

Mabel Newcome of Vassar College has said, "The failure of women now is not from lack of preparation. The problem today for women is lack of motivation."

That motivation must come from the few—the few of us who have had the opportunity to see the needs. We are the ones who must shoulder the responsibility to communicate the need and evoke the response. A well organized minority is always superior to an unorganized majority.

Our first need, perhaps, is to communicate with ourselves, asking the critical questions: WHY an auxiliary to my husband's medical organization? Why is my support important?

If each one truly communicates, giving recognition to our aims, our program, and our accomplishments, the auxiliary will stand the test of scrutiny. We can invite it—and we should invite it: scrutiny by our own members, members of our medical societies, potential members, and the public. One of the most overlooked aspects of evaluation is the process of being asked penetrating questions and being required to give a considered answer.

Our devotion to medicine is the noble response of a wife to a husband who has chosen a life of service. The "Marriage of True Minds" brings recognition to this high calling and our highest conscience will call us to contribute and support him in his leadership.

Compliance to the dictates of our conscience will lead each auxiliary member and doctor's wife to contribute to our training of leaders—women to work side by side with

(Continued on Page 300)



Whaddaya mean would I fix my own plumbing?
Of course I'd fix my own plumbing. I'm a plumber.

Whether the sinusitis patient comes to you at the first sign of trouble or as a last resort, you can give him the relief he's looking for with Novahistine Singlet.

A single tablet provides prompt analgesic effect for relief of sinusitis pain. Then Novahistine Singlet also attacks the underlying cause of the headache—helping to open blocked respiratory passages and restore normal sinus drainage. The continuous decongestant effect produced by one Novahistine Singlet every 8 hours reduces the chances of acute sinusitis progressing to chronic stages.

Use cautiously in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Tell ambulatory patients that Novahistine may occasionally cause drowsiness. Each tablet contains phenylephrine hydrochloride, 40 mg., chlorpheniramine maleate, 8 mg., and acetaminophen, 500 mg.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis Dow

NOVAHISTINE® SINGLET(TM)

For the relief of sinusitus pain and congestion.

(Continued from Page 298)

their husbands, giving impetus to the AMA crusade to maintain and improve the health of our people. The ideals which are the basis of our organizations will not stand against the buffeting of social planners or the indifference of the majority unless we have an upsurge of individual determination to maintain our integrity.

We are important factors in the making of a truer image of the modern doctor. We know him well. He is equipped with the latest that science has to offer, dedicated to giving the best to his patients, well-trained and hard-working, stringently policed by and policing his own colleagues—and, what is more, accepting his obligations as a citizen and a community leader as never before.

Our philosophy must inevitably reflect that of our husbands, and it is our adherence to these truths as we know them which will lead us to project into our communities the profession's concern for the health needs of the public. Our service is the best possible communication to the layman. While we recognize that our actions speak more loudly than words, the words which follow our demonstration are important and better received. Our role as interpreters of medicine's ideals requires our sincerity of purpose.

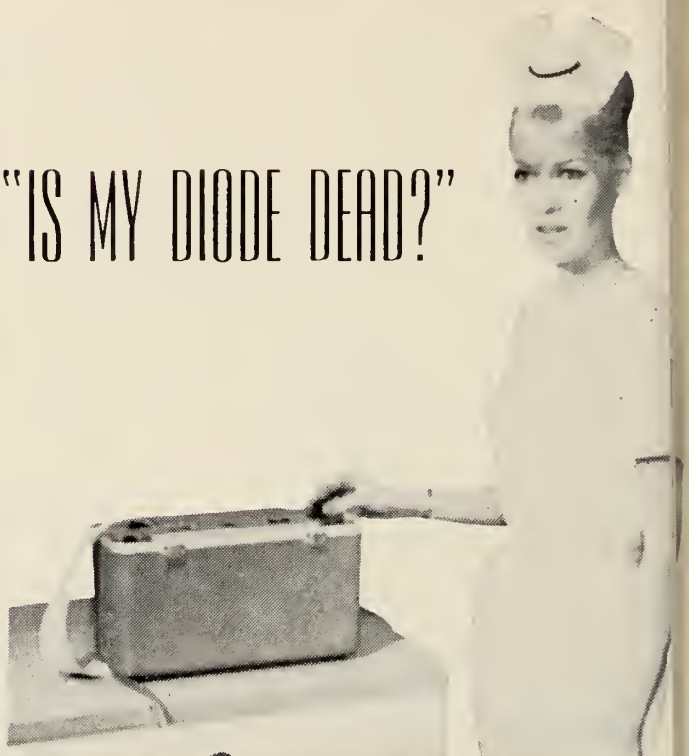
We are, you see, unique among service organizations. We are the wives of physicians, and in the health field this gives us unusual responsibilities. We are bound to medicine, as Anthony to Cleopatra or ham to eggs.

Medicine is an objective art, practiced in a subjective manner. In the final analysis service is an affair of the heart, an act of conscience. Our conviction and our surrender to this way of life will lead us to communicate, to project, to grow, to influence for good, as well as to hear our husbands say "they, indeed, are good trademarks."

Eloise Bryant Crenshaw

Mrs. James F. Crenshaw

"IS MY DIODE DEAD?"



If it's not your diode, we'll bet it's your resistor. In any event that EKG won't work, so call us. Better yet, let's get together on scheduled maintenance for all your equipment. It will keep everything alive, and you won't have that hurt feeling.

Our competent men have rendered maintenance service to happy customers for years. Let us tell you about it.

Yes, I'm interested in good equipment maintenance. Send a good man and we will talk it over.

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BIRMINGHAM, ALABAMA Phone 251-4176

a rapid lift from the hell of depression



Doré Illustration
from
Dante's Inferno

often relieves mental pain in 2-5 days

NORPRAMIN®
(desipramine hydrochloride)

Norpramin is a rapid-acting specific drug for the treatment of depression. Depressive signs and symptoms—sometimes described as "mental pain"—typically begin to improve in 2-5 days. Patients are more hopeful, less empty and less weighed down by their troubles. Norpramin has only slight sedative qualities, nevertheless anxiety *secondary to depression* is frequently relieved as depression is lifted. If anxiety or tension persists it can be controlled by adding a tranquilizer or by reducing dosage. Norpramin is not a MAO inhibitor. Side effects are usually mild.

DOSAGE AND ADMINISTRATION

Optimal results are obtained at a dosage of about 150 mg./day—two 25 mg. tablets t.i.d. After achieving optimal results, a maintenance dose (50-100 mg./day) should be sought.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

IN BRIEF:

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

Contraindications and Precautions: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established.

Adverse Effects: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

Supplied: Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

Woman's Auxiliary Fall Board Meeting, Birmingham, Alabama



Mrs. R. K. Wilson, Aliceville, Recording Secretary; Mrs. W. R. Sutton, Blountsville, Parliamentarian; and Mrs. J. F. Crenshaw, President, Birmingham.



Mrs. John Denton, Jr., National Vice President, Woman's Auxiliary to the Student American Medical Association.



At "The Club" for luncheon are Mesdames W. L. Hawley, W. H. Robertson, Birmingham; M. S. DeWeese, Columbia, Missouri; David Smith, Madison, Wisconsin; Gilder Wideman and G. P. Falletta, Birmingham.



There was a large delegation from Montgomery, Alabama. Shown above are Mesdames William L. Smith, L. R. Pummer, H. J. Till, R. M. Garrett, W. B. Sorrell, and E. F. Campbell. Not shown is Mrs. W. F. Little.



Mrs. William L. Smith, National Committee Representative, Montgomery; Mrs. William Rosser, Radio and Television Chairman, Birmingham; and Mrs. John M. Chenault, Orientation Chairman, Decatur.



Mrs. William G. Thuss, President-Elect, Woman's Auxiliary to the Southern Medical Association and Mrs. Gilder Wideman, who gave a report on Southern Medical activities.



Mrs. J. K. V. Willson, Legislative Chairman, Mobile; Mrs. Albert Tatus, Jr., International Health, Tuscaloosa; and Mrs. J. D. Rayfield, Rural Health, Sylacauga.

TOPICAL TREATMENT

TYPICAL RESULTS



PRIMARY PYODERMA



AFTER TREATMENT WITH
'NEOSPORIN' ANTIBIOTIC OINTMENT
AND SALINE COMPRESSES

with **'NEOSPORIN'**® brand

Polymyxin B-Neomycin-Bacitracin

ANTIBIOTIC OINTMENT

Each gram contains:

'Aerosporin'® brand Polymyxin B Sulfate 5,000 Units

Zinc Bacitracin 400 Units

Neomycin Sulfate (equivalent to 3.5 mg. Neomycin Base) 5 mg.

Tubes of ½ oz. and 1 oz.

- clinically effective
- comprehensive bactericidal action against most Gram-negative and Gram-positive organisms, including Pseudomonas
- rarely sensitizes

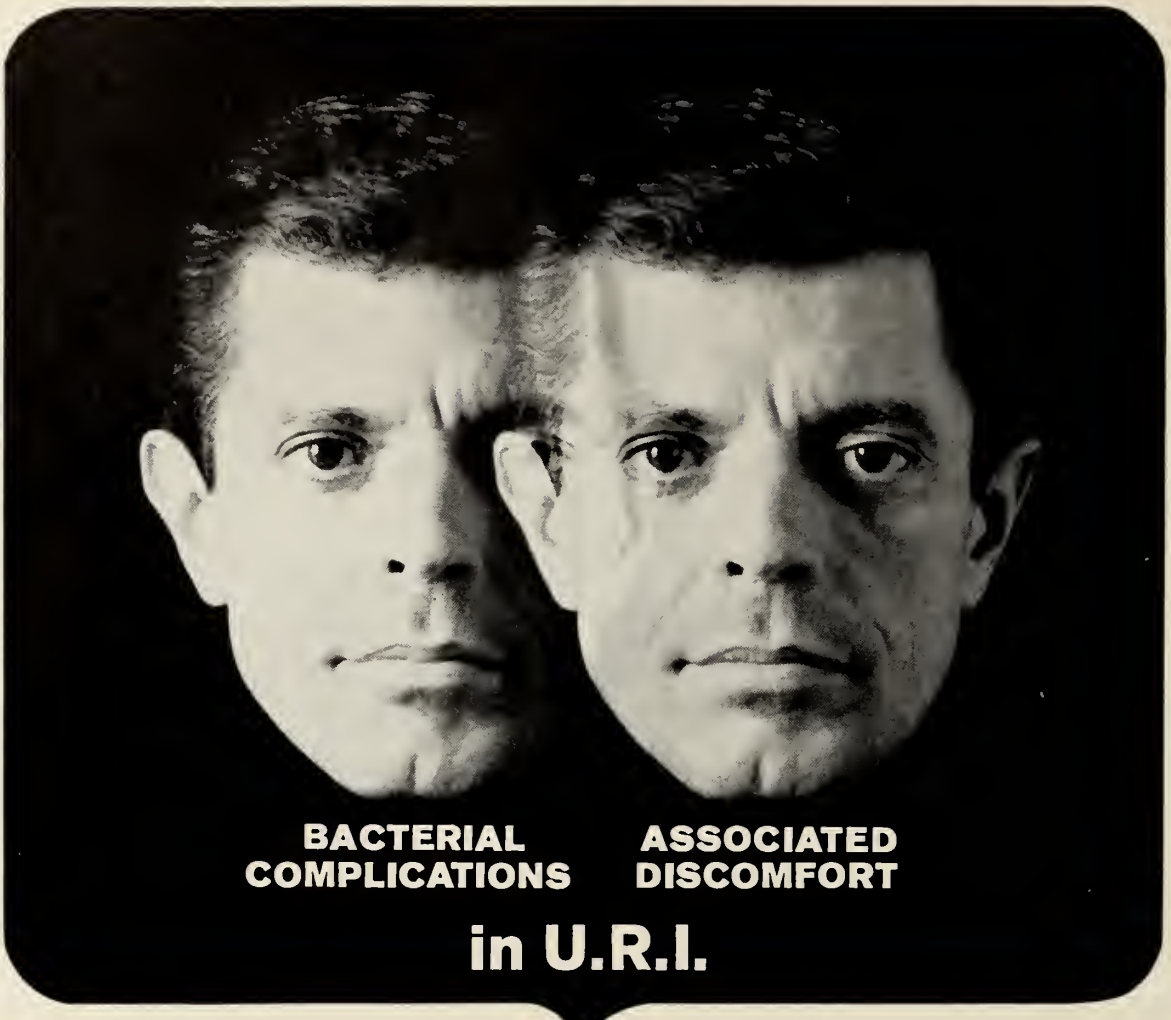
For the eradication of infectious organisms in a wide range of dermatologic disorders: impetigo, ecthyma, pyodermas, sycosis vulgaris, paronychia, traumatic lesions, eczema, herpes and seborrheic dermatitis. Prophylactically, for protection against bacterial contamination in burns, skin grafts, incisions and other clean lesions, abrasions and minor cuts and wounds.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

Contraindication: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Complete literature available on request from Professional Services Dept. PML.

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BRING THE TREATMENT TOGETHER
IN A SINGLE PRESCRIPTION

ACHROCIDIN®

Tetracycline HCl-Antihistamine-Analgesic Compound

Each tablet contains:			
ACHROMYCIN® Tetracycline HCl	125 mg	Caffeine	30 mg
Acetophenetidin (Phenacetin)	120 mg	Salicylamide	150 mg
		Chlorothen Citrate	25 mg

Effective in controlling complicating tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects include drowsiness, slight gastric distress, anorexia, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation), photodynamic reaction to sunlight and increased intracranial pressure (in young infants). Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals. Patient should avoid direct exposure to artificial or natural sunlight; and should not drive a car or operate machinery while on drug. Reduce dosage in impaired renal function. Stop drug immediately at the first sign of adverse reaction.

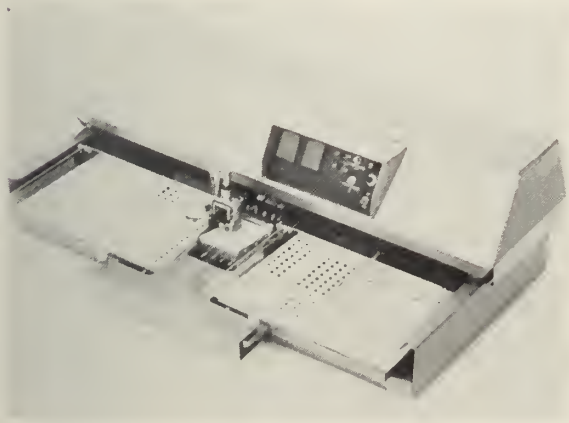
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Lederle

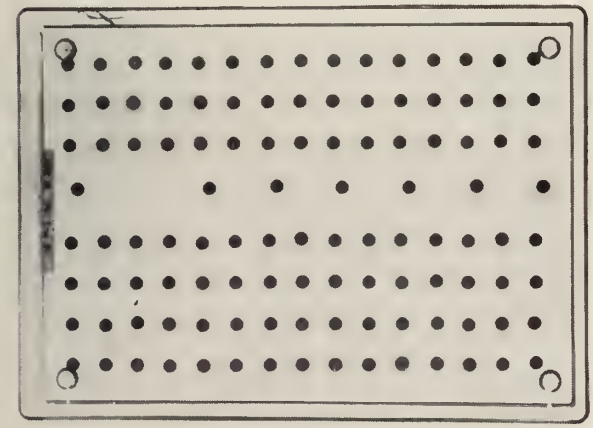
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Guthrie PKU, MSUD & Galactosemia Tests Automated

Laboratory time required to seed and index agar plates used in Guthrie tests for Phenylketonuria, Maple Syrup Urine Disease and Galactosemia has been reduced 1,200 per cent according to an estimate made by Dr. R. Wendell Coffelt, medical staff pediatrician, St. Joseph Hospital, Burbank, California. The advance has been made through employment of a bio-medical specimen punch indexing instrument which simultaneously punches three discs from the blood impregnated filter paper, positions the discs precisely on three agar plates and imprints the card with date, run number and location of all three discs. A fourth disc, not now being used, is available for future application as the next congenital metabolic disorder test is added. The machine, a product of Fundamental Products Company of North Hollywood, California, has been in use for three months in the Testing Center for Inborn Errors of Metabolism, located at St. Joseph's. The Center is headed by Dr. Coffelt and Dr. Reuben Straus, Director of Laboratories, with the technical assistance of Raymond Grimes, Microbiologist.



Fundamental Products Company punch indexing instrument which punches discs from blood impregnated filter paper, positions in agar trays and imprints card with date, run number and location. Three agar trays, for PKU, MSUD and Galactosemia, are shown in position. Empty row down the middle of each tray is for placement of control discs. Filter paper card is shown ready for next punch.

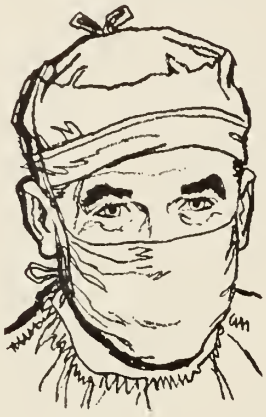


Agar tray 16 hours after placement of specimen discs. Control discs down center of tray show proportionately larger turbid zones of growth around discs. Discs being tested all show normal growth rings relative to control disc to which has been added normal blood control quantities of L-phenylalanine.

Effectiveness of the Fundamental Products Company unit is underscored by the assimilation of a tremendously increased work load at the Testing Center during the period concerned. When the Testing Center was started in 1963, tests were offered for infants born at St. Joseph's and five other hospitals. At that time only the Guthrie test for PKU was performed. Subsequently Guthrie tests for Maple Syrup Urine Disease and Galactosemia were added and all three are now routinely performed on all samples received. During this period more than 50 Southern California hospitals with a birth list of almost 50,000 per year were added to the program and 3,787 tests were performed on patients in state mental institutions. In all, a total of more than 30,000 PKU, 22,837 MSUD and 18,816 Galactosemia tests have been performed. During the period immediately before installation of the Fundamental Products Company unit, the Center was running 600 to 700 tests per week and, because of the mechanics involved in performing the tests, it was necessary to accumulate samples and run them all during one selected day of the week. This batching was done once a week with a

(Continued on Page 309)

DOCTOR! A MINUTE, PLEASE!



We know you're besieged by insurance men but . . . The Alabama Medical Association has a Special Plan for you.

Your Insurance Committee Has Approved It and Given Us an Exclusive Endorsement.

They want you to see . . .

THE PLAN THAT PROTECTS YOUR INCOME!
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for psychiatric treatment

Peachtree Hospital, located in Atlanta, Georgia, is a complete psychiatric, alcoholic and drug addiction treatment facility accredited by the Joint Commission on Accreditation of Hospitals ☐ The hospital has 65 beds, 47 of which are devoted to the care of psychiatric patients and 18 of which, in a separate area, are for patients with acute cases of chronic alcoholism or drug addiction ☐ Treatment procedures include psychotherapy, electroconvulsive shock therapy, subinsulin coma and chemotherapy ☐ *We will be pleased to provide further information upon request.*

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Star-spangled way to sweeten up your future

The old American proverb says, "money isn't everything, but it sure helps."

And that goes double for the money you put in U. S. Savings Bonds. Because this money helps two important ways.

First, it helps your future. Putting youngsters through college. Building homes and summer cottages. Buying cruises for you and the spouse. You dream it; Bonds can deliver it.

Second, it helps your country now, by making Uncle Sam a stronger influence in an unsettled world.

Your fellow Americans have tucked over 48 billion dollars into U. S. Savings Bonds. Why not join them? There's no safer investment anywhere in the world.

Quick facts about Series E Savings Bonds

- ✓ You get back $4 for every $3 at maturity (7¾ years)
- ✓ Your Bonds are replaced free if lost, destroyed or stolen
- ✓ You can get your money when you need it
- ✓ You pay no state or local income tax and can defer payment of federal tax until the Bonds are cashed

Buy E Bonds for growth
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Buy U.S. Savings Bonds

STAR-SPANGLED SAVINGS PLAN
FOR ALL AMERICANS



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On Stelazine® **brand of trifluoperazine**
she's calm and alert

When a tranquilizer is needed, 'Stelazine' can regulate the level of anxiety so that the patient is unlikely to overreact to stress but is not tranquilized into psychic inertia. Patients on 'Stelazine' often experience a sense of mental alertness and, because they feel so much better, are more interested in their normal activities.

Contraindicated in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects,* usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems.

Before prescribing, see SK&F product Prescribing Information.

Photograph professionally posed.

SK&F

Smith Kline & French Laboratories

(Continued from Page 305)

consequent delay in catching possible positives of from one day to seven days, with a median of three and one-half days. During this period, filing of finished tests became increasingly heavy and a constantly increasing backlog was accumulating.

Since the Fundamental Products instrument has been in use, the Center is running up to 1,800 tests per week and a run is made every day. It is possible, therefore, to detect a positive the day after birth. Recent investigation has determined brain damage may begin immediately after birth and continue at the rate of 2 points of I. Q. per week until arrested by diet control.

The greatly increased work load possible with the introduction of the Fundamental Products instrument is conducted with the same staff, no increase has been made. Further, according to Mr. Grimes, tension and strain of work overload has been reduced and the level of staff efficiency has been substantially increased.

The Fundamental Products instrument will handle 500 filter paper cards an hour, placing up to 2,000 discs and sustaining a positive identification of their location. This is believed to be the first bio-medical instrument which will place specimens in any of a number of varied positions, in this application one of 420 possible locations, and permanently record its location. These unique functions as well as basic structure have patents applied for by Mr. Robert Phillips of Fundamental Products Company. In addition to reducing the time required per test, use of the instrument has become a great help to accuracy. According to Dr. Coffelt, the linearity of placement possible with the machine is a substantial assistance to reading the plates. Use of the machine will save the time of one technician in the smallest laboratory. Larger facilities will save correspondingly larger number of man hours.

Effectiveness of the testing program and the use of the Fundamental Products instrument was demonstrated recently when a positive PKU was detected on an 8 hour test of new born male child. The pregnant woman, an American Indian, was referred to Dr. Coffelt by the University of California at Los Angeles Health Center because she then had a three year old boy who was phenylketonuric and was under treatment at the UCLA Health Center. Family history indicated the woman had a retarded half-sister and a retarded uncle. Tests conducted by the Center, under Dr. Coffelt's direction, gave a 6 to 8 milligram PKU positive on the 8 hour test, 10 milligram positive on the 31 hour test, 12 to 20 positive on the 55 hour test and over 20 at discharge.

MID-YEAR MEETING

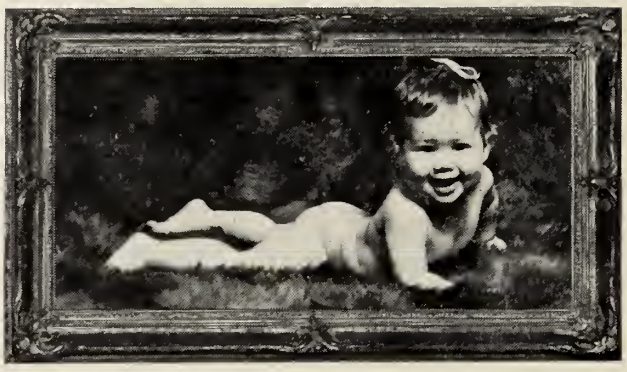
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NOVEMBER 18, 1965

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1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. *8*:73-77 (Jan.) 1957

2—Asher, L.M.: Am. J. Digestive Diseases *4*:272 (Apr.) 1959

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Side Effects: Dry mouth, blurring of vision or drowsiness may occur.

Contraindications: Withhold in glaucoma, bladder or g.i. obstruction, cardiac arrhythmias and in sensitivity to anticholinergics or phenobarbital (Piptal-PHB). Caution should be observed in patients with prostatic hypertrophy.

Administration and Dosage: PIPTAL or PIPTAL-PHB Tablets: One tablet three times a day before meals and one or two tablets at bedtime. (PIPTAL-PHB Elixir: One teaspoonful three or four times daily for adults and children over six years of age.)

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The acute phase of subdeltoid bursitis, tendinitis and associated periarticular inflammation usually responds promptly and dramatically to Butazolidin, brand of phenylbutazone. Pain and tenderness may be relieved within 24-48 hours and mobility of the affected arm quickly restored. Full recovery is frequently achieved within 7-10 days so that therapy is generally of short duration. Calcific deposits are not specifically affected by treatment, but their presence does not appear to retard symptomatic improvement.

Phenylbutazone has not replaced physiotherapy, x-ray treatment, or local injections of hydrocortisone in the more chronic conditions, but it may advantageously be combined with these measures.

Contraindications
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage
Initially, give 400 mg. daily (one tablet or capsule q.i.d.), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. To minimize gastric distress, Butazolidin alka capsules may be the preferred form.

Note: The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

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Each capsule contains:	
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dried aluminum hydroxide gel	100 mg.
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Margaret S. Klapper, M. D., Director

Division of Continuing Education, Medical College of Alabama

Birmingham, Alabama

"A well-trained, sensible family doctor is one of the most valuable assets in a community, worth today, as in Homer's time, many another man . . ." Sir William Osler

The Division of Continuing Medical Education of the Medical College of Alabama enters its fourth year with vigor nurtured by the stimulation and enthusiasm of its principal participants—the practicing physicians of Alabama.

Insecure at the outset, and with the wavering steps of infancy, the first course was offered in June of 1963 to 32 physicians. By 1964-65 it confidently broadened its scope of activities to include seven intramural courses, two refresher courses of one week each for specific physicians, and two extramural programs totalling nine bi-monthly seminars. It cosponsored and cooperated with other health groups in the offering of four additional programs. A total of 338 practicing physicians participated in its specific programs, and an additional 408 physicians in the cosponsored programs.

The Division soon recognized that its primary purpose of physician education could be better served through expressions of interest and participation in other areas of medical, paramedical, and health education. Twelve teaching programs at Mobile General Hospital and three at Tuskegee Veterans Administration Hospital are conducted yearly for physician-staff. By participation at planning meetings, it endorses programs in the paramedical areas. The Division accepted gratefully an invitation from the Alabama Academy of General Practice to join it and the Department of Health Education and Welfare in preparing a shop talk "Smoking and Disease."

During 1963-64, the area of educational television was entered when the Division cooperated with the Alabama Diabetes Association in presenting a series of twelve thirty-minute programs "The Diabetic Life" for adult lay education. This was so successful that a similar program was repeated during 1964-65, and will probably be continued yearly. For the first time, in 1965, television was utilized for physician education by the Alabama Heart Association with the University of Alabama and the Division of Continuing Medical Education. The responses of physicians to these programs will be most significant in determining the value and future use of television as a means of continuing medical education.

The Council on Medical Education of the American Medical Association has been invited to visit the Medical College and survey the Division of Continuing Medical Education. This site visit will be through the Voluntary Survey and Accreditation Program for institutions active in continuing medical education. Constructive advice and helpful suggestions are anticipated from this survey.

The planning of programs for 1965-66 is well under way, and you have recently received advance notice of the ten intramural courses to be offered during this interval. Those yet to be held are:

"Clinical Diagnosis of Heart Disease"—December 8-9, 1965; "Symposium on Burn Management—Wound Healing"—December 10-11, 1965; "Medicine of Tomorrw: Recent Advances in Internal Medicine"—January 10-14, 1966; "Progress in Obstetrics and Gynecology"—February 17-18, 1966; "Radioisotope Training Course"—March 7-11, 1966; "Rehabilitation of Motor Disorders"—March 11-12, 1966; "Pediatrics—1966"—March 29-31, 1966.

Additional programs will doubtlessly be cosponsored.

The most important determinant of the quality of medical care is the continuing self-renewal of the physician. The methods and materials by which he may do so are many and diverse, and are an individual responsibility. Motivation, dedication, and self-education are far more important than the wrappings in which the material comes.

Although students always, and learning continuously, a return to the pupil role completely can be a refreshing and rewarding experience for the physician. Removed from the environs where learning must be picked up bit-wise through long days of practice, practitioners share with preceptors an enjoyable learning experience, and both may leave with a sense of renewal and rededication from this medical retreat.

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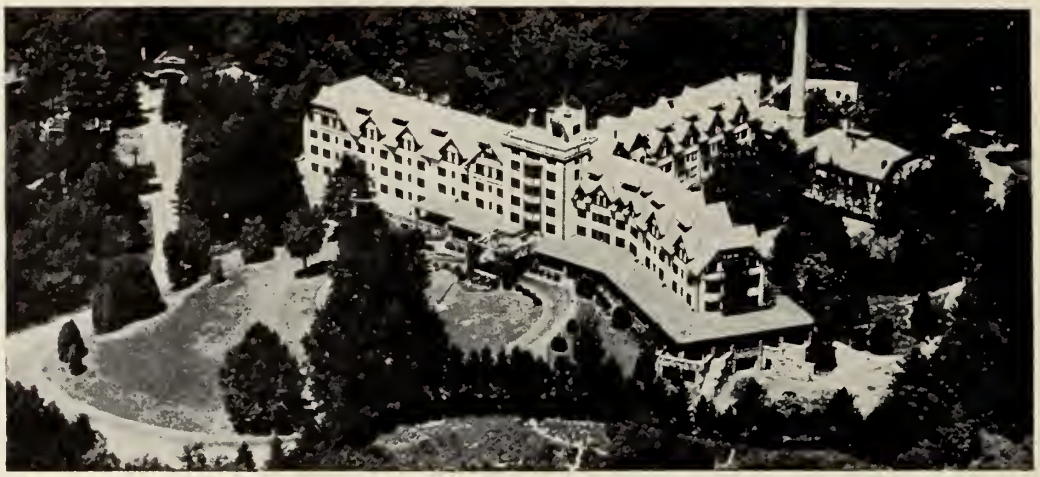
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Marks, V., and Dawson, A.: Brit. M. J. 1:293, 1965.

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Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal of hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

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NOVEMBER 1965



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(1) Portnoy, J.; Brewer, J. and Harris, A.: PUBLIC HEALTH REPORTS, *77:*645-652, August 1962. (2) Joseph, J. M. and Warner, G. S.: A WORKSHOP MANUAL. Md. State Dept. Health, Bureau of Lab., Balto., Md., September 1962. (3) Wollenweber, H. L.: OFF. PATH., *2*, February 5, 1963. (4) Portnoy, J.: MILIT. MED., *128:*414-417, May 1963. (5) Portnoy J.: THE AMER. JOUR. OF CLIN. PATH., *40:*473-479, November 1963. (6) Buck, A. A. and Mayer, H.: THE AMER. JOUR. OF HYG., *80:*85-90, July 1964. (7) Brown, W. J.; Donohue, J. F. and Price, E. V.: PUBLIC HEALTH REPORTS, *79:*496-500, June 1964. (8) Clayton, J. L.; Lindhardt, E. M. and Fraser, R. S.: PUBLIC HEALTH LAB., *22:*206-207, November 1964. (9) Lucatorto, F. M.; Katz, B. D. and Toto, P. D.: THE J.A.D.A., *69:*697-699, December 1964. (10) Portnoy, J.: PUBLIC HEALTH LAB., *23:*43, March 1965. (11) Reed, E. L.: PUBLIC HEALTH LAB., *23:*96-103, May 1965.



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THE JOURNAL

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Montgomery, Alabama

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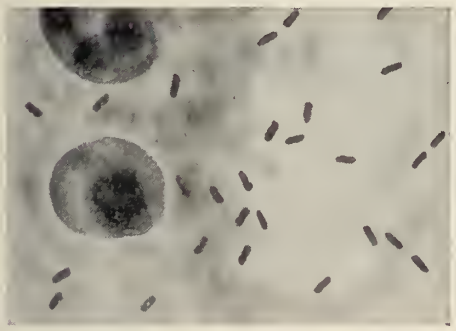
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Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately *25 mg. per pound* of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Buff-colored, scored Caplets® of 500 mg. for adults, conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1,000. 250 mg. for children, available in bottles of 56 and 1,000.

References: (1) Carroll, G.: Urologists' Letter Club, June 1, 1964. (2) McDonald, D. F., and Short, H. B.: Address to the Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, New York, Oct. 26-28, 1964.

Winthrop

Winthrop Laboratories, New York, N.Y. 10016



(mepenzolate bromide)

helps restore normal motility and tone

Cantil (mepenzolate bromide) works in the colon. In irritable colon, spastic colon, ulcerative colitis and other functional and organic colonic disorders, it acts to:

- control diarrhea/constipation
- relieve spasm, cramping, bloating
- make patients more comfortable

with little effect on stomach, bladder or other viscera.

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects. Blurring of vision or dryness of the mouth were occasionally seen and were usually managed with a reduction in dosage. Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250.

CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

President's Page



One of the most critical unmet medical needs in Alabama at this time is the provision of hospital care for indigent people of all ages. This need is partially and inadequately met in some of the large cities and counties by city-county hospitals, financed by local funds, for the care of indigent citizens of these counties. Such provision is not made for the large majority of the citizens of the State who live outside these Metropolitan areas.

Dr. E. L. McCafferty, Chairman of the Committee on Legislation, has initiated a study of this problem to determine the feasibility of establishing or designating regional hospitals throughout the state for the care of indigent patients. Use could be made of existing facilities with State financial support in proportion to the utilization by indigent patients from the region involved.

Such a plan would not only provide significant help for needy citizens, but would encourage more physicians to practice in the less heavily populated areas of the State. One of the most frequently voiced deterrents to such location has been the lack of proper hospital facilities to care for indigent patients. This would further strengthen the intent of the Medical Scholarship Act of 1965 to secure more doctors for the smaller towns of Alabama.

Legislative authority already exists for the State Board of Health to co-operate and make contracts with any local political subdivision or agency in the acquisition, building, equipping, maintenance, and operation of any public hospitals, health centers, and related facilities for the treatment of any type of disease.

An effort has been initiated by the State Board of Health to set up an indigent care program; but because of lack of funds, this effort has been only a feeble beginning. Now is the time to formulate long-range plans to procure adequate State financing for a realistic indigent care program.

Meanwhile, local efforts are being made. On November 30, 1965, a Statewide affirmative vote will be required on Amendment 28 to permit citizens of Mobile County to impose upon themselves an increase of three mills in ad valorem taxes to assist in the operation of Mobile General Hospital. All members of the profession throughout the State should work for a **yes** vote on Amendment 28 to secure this essential financial help for one of our outstanding local hospitals ministering to the needs of indigent patients of Mobile County and the surrounding area. Such a vote will only allow the citizens of Mobile County to tax themselves for this purpose.

James G. Donald, M. D.

James G. Donald, M. D.,
President



following infection

STRESSCAPS B and C vitamins in therapeutic amounts...help the body mobilize defenses during convalescence...aid response to primary therapy. The patient with a severe infection, and many others undergoing physiologic stress, may benefit from STRESSCAPS.

Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 (one month's supply) and 100 (three months' supply).

STRESSCAPS®

FOR PROFESSIONAL RECOMMENDATION ONLY

Stress Formula Vitamins Lederle

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8693 4

Lederle



ABOUT THANKSGIVING DAY, 1965

Almost as traditional as the nation's observance of Thanksgiving Day during the month of November each year is the function of the press in commenting on the occasion. Frequently editors are hard-pressed to find local reasons for gratitude and this task becomes all the more difficult when the scope is enlarged.

So it is with the *Journal* of the Medical Association of the State of Alabama. Reasons for thanksgiving, when measured against events of the past 12 months, are indistinct at first glance. Organized Medicine has been made a whipping-boy by the national administration and it has suffered defeat after defeat at the hands of politicians in Washington.

Alabama's delegation in the U. S. House of Representatives (with but one exception) held firm in its support of Medicine, but the steamroller tactics of Johnson, Reuther & Co. proved too overpowering and they were swept into the maelstrom of defeat along with the cause they espoused.

Medicare—enacted after a 30-year fight—and a few other bills intended to federalize the practice of medicine in this country have given Medicine little cause to rejoice at this season.

But it is a long road that has no turning and signs indicate that physicians are beginning to see a ray of light shining through the political darkness.

For the first time in its long history, the Medical Association of the State of Alabama has become aware of its political strength and has demonstrated its power to win friends and influence legislators at the state level. At the national level representatives of MASA, at great cost to their own practices, have moved with confidence and vigor to make our views known and to demand that our voices be heard.

For this, and for the promise that what we have started is but a sample of what we intend to accomplish in the days ahead, we have reasons sufficient to be thankful. For our lately-acquired knowledge that it is no longer possible to practice the most advanced medicine ever known to man, unfettered by government control, we can be doubly thankful.

For notable scientific advances in fields of surgery and medicine during the past year we and all mankind can regard with humble gratitude the spirit which inspired this Thanksgiving Day in the year of Our Lord, 1965.



more complete relief for the "dyspeptic"

DACTILASE®

Dactilase provides comprehensive therapy for a wide range of digestive disorders. Its antispasmodic and anesthetic actions rapidly relieve pain and spasm. Dactilase decreases hypermotility without inducing stasis. In addition, it supplies digestive enzymes to help reduce bloating, belching and flatulence. Dactilase does not interfere with normal digestive secretions. Very often it can be a most useful answer to the dyspeptic's needs.

DACTILASE: Each tablet contains: Dactil® (piperidolate hydrochloride), 50 mg.; Standardized cellulolytic* enzyme, 2 mg.; Standardized amylolytic enzyme, 15 mg.; Standardized proteolytic enzyme, 10 mg.; Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established. **As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

Side Effects and Contraindications: DACTILASE is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201



"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.





the sedentary life is often the seat of low back pain

The human spine is not engineer
prolonged sitting at desks, pianos
writers and drafting boards. The st
set up by the heavy, forward-tilte
and trunk, balanced precariously
insufficient base, result in strain
dorsal musculature, particularly
low lumbar level.

The unusual muscle-relaxant and
gesic properties of 'Soma' make it
cially useful in the treatment of lo
sprains and strains. 'Soma' is
prescribed ☐ **to relieve pain** ☐ **to**
muscles ☐ **to restore mobility.**

Indications: 'Soma' is useful for manage
muscle spasm, pain, and stiffness in a va
inflammatory, traumatic, and degenerative
loskeletal conditions. It also may act to no
motor activity in certain neurologic distur

Contraindications: Allergic or idiosyncrati
tions to carisoprodol.

Precautions: 'Soma', like other central
system depressants, should be used with
in patients with known propensity for tak
cessive quantities of drugs and in patien
known sensitivity to compounds of similar
cal structure, e.g., meprobamate.

Side Effects: The only side effect reported
frequency is sleepiness, usually on high
recommended doses. An occasional patie
not tolerate carisoprodol because of an in
reaction, such as a sensation of weakness
rarely observed reactions have included di
ataxia, tremor, agitation, irritability, heada
crease in eosinophil count, flushing of fa
gastrointestinal symptoms.

One instance each of pancytopenia and
penia, occurring when carisoprodol was
istered with other drugs, has been reported
an instance of fixed drug eruption with caris
and subsequent cross reaction to meprob
Rare allergic reactions, usually mild, have i
one case each of anaphylactoid reaction wi
shock and angioneurotic edema with resp
difficulty, both reversed with appropriate t
In cases of allergic or hypersensitivity re
carisoprodol should be discontinued and a
ate therapy initiated. Suicidal attempts m
duce coma and/or mild shock and resp
depression.

Dosage: Usual adult dose is one 350 mg
three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white
and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circula

for the relief of low back sprains and strain

SOMA
(CARISOPRODO

Wallace Laboratories, Cranbury, N.J.

Butazolidin® alka

Each capsule contains:
Butazolidin, brand of
phenylbutazone 100 mg.
dried aluminum,
hydroxide gel 100 mg.
magnesium trisilicate 150 mg.
hyoscine
methylbromide 1.25 mg.

in painful shoulder



Geigy

Therapeutic Effects
The acute phase of subdeltoid bursitis, tendinitis and associated periarticular inflammation usually responds promptly and dramatically to phenylbutazone. Pain and tenderness may be relieved within 24-48 hours and mobility of the affected arm quickly restored. Full recovery is frequently achieved within 7-10 days so that therapy is generally of short duration. Calcific deposits are not specifically affected by treatment, but their presence does not appear to retard symptomatic improvement.

Phenylbutazone has not replaced physiotherapy, x-ray treatment, or local injections of hydrocortisone in the more chronic conditions, but it may advantageously be combined with these measures.

Contraindications
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage
Initially, give 400 mg. daily (one capsule q.i.d), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. Butazolidin alka contains antacids and an antispasmodic to minimize gastric upset.

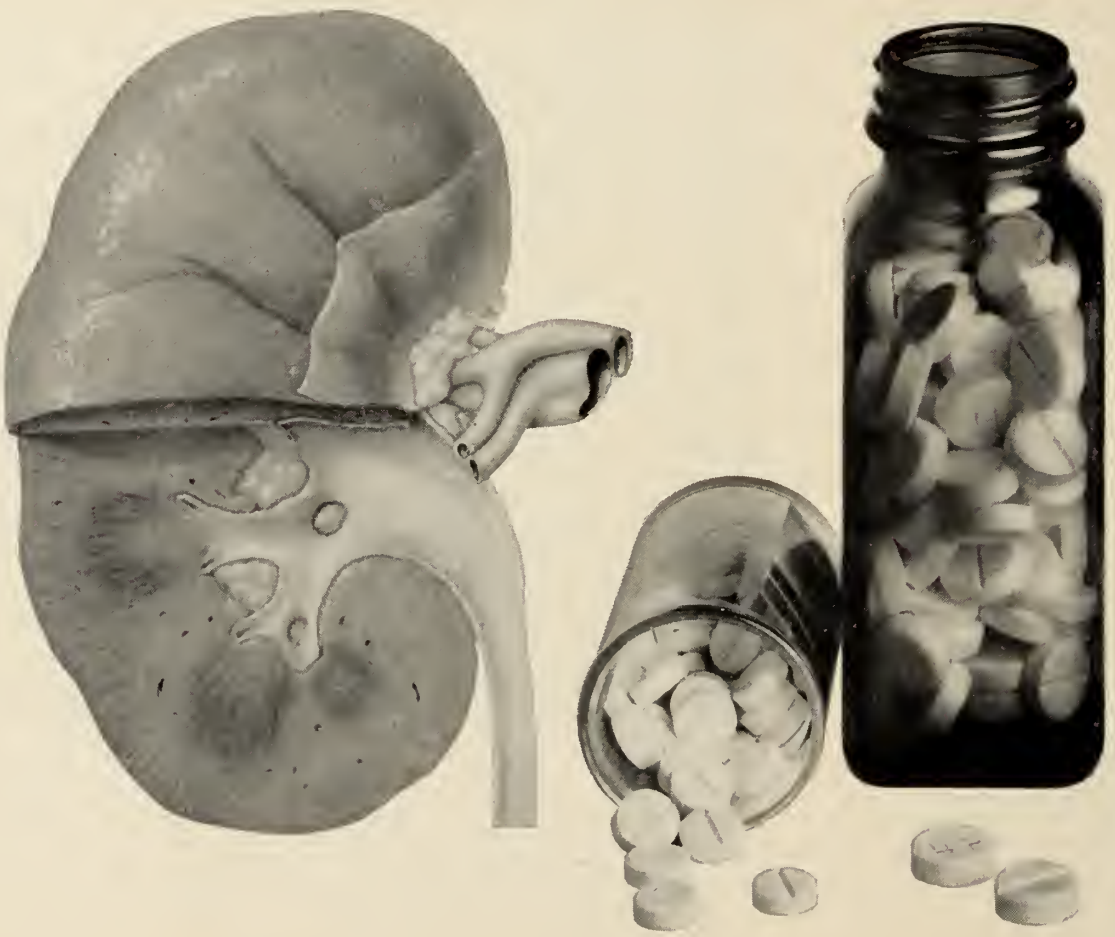
Note: The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

Also available:
Butazolidin®
brand of phenylbutazone
Tablets of 100 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

BU 4010P

at Merck Sharp & Dohme...



understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

• Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

Guest Editorial....

UNIONS CHALLENGE THE PATTERN OF HEALTH CARE

By Robert T. Hood, Jr., M. D.

Associate Editor, Bulletin of the Los Angeles County Medical Association

Possibly the most far-reaching consequence of the 1964 election was the tremendous boost in union power in Washington. Congress is under constant and increasing pressure from union sources to further the long-range objectives of union planners. Since health care has been assigned a top priority, the push for union's specific health proposals will be intense, so intense that it may generate medicine's long needed catalyst for effective unity.

"Nation's Business," July 1965, in an article entitled "Labor's Next Decade" summarized their gatherings from top union leaders, businessmen, government officials and labor relations attorneys.

Among the conclusions:

1. "Unions will attempt to assert more influence in and on the administration of government and on legislation of all kinds."

2. "Consequently, there's greater risk that government will side with unions even more than it has in all aspects of your business, particularly in your relations with employees."

3. ". . . the muscle unions flex may increase far out of proportion to the number of members because of political considerations and the size of unions, which will expand through mergers in closely related industries."

4. "New and younger unionists stepping into leadership posts will shift their focus from the traditional wages, hours and working conditions to political, community and social problems."

5. "Union demands on employers will reflect growing interest in job security, health insurance and pension benefits, and less work for more pay."

Clearly the objective is a labor government and the progress toward that goal is startling.

In 10 years since COPE (Committee on Political Education) merged from the fusion of the old CIO Political Action Committee and the AFL Labor's League for Political Education, union supporters in Congress have increased from 40 to 63 in the Senate and from 190 to 298 in the House.

Says COPE, "Unions will put political activity on an equal basis with collective bargaining, when they realize that there is a limit to what they can gain from employers through bargaining."

Says Walter Reuther, "We'll become even more deeply involved in the political and legislative process as we de-emphasize our role as a purely economic force and become a social force dealing with the problem of the whole of society, such as education, housing and civil rights."

Possibly a truer motive behind the shift from wages to benefits is offered by Sylvester Petro, New York University Law School professor and labor relations expert: "It becomes more and more obvious that the average American worker is not greatly interested in unionism. The free enterprise system is so productive, rewards workers so generously, the unions must have special privileges of compulsion to organize employees on any large scale—special privileges they can get only from government."

Do you wonder why Dirksen stands firm in his opposition to repeal of Taft-Hartley's Section 14(b)?

* * *

A new union magazine "I U D Agenda" has appeared this year. It is the official monthly publication of the Industrial Union Department, AFL-CIO. Its president, Walter Reuther. Its purpose, "a monthly magazine for people who are working actively on the great unfinished business of democracy's agenda for all humanity." Significant is the subject of Vol. 1, No. 3: "After Medicare, What? America's Unmet Health Needs."

In the issue's preamble, the American Medical Association is designated as the adversary. It is accused of "bitter opposition" to the Medicare bill which in "Agenda's" view will provide only a "step toward minimal health care protection for senior citizens."

The state of American health is deplored because the United States does not have the greatest life span, nor the lowest maternal mortality or infant mortality. In fact, America must be a frightful place in which to live.

The first article is by Milton I. Roemer, M. D., Professor of Public Health, UCLA, "Cutting Out The Waste . . . Meeting The People's Needs." Here's what the expert tells the AFL-CIO.

1. The Pharmaceutical Industry makes huge profits, which come from sick people's pockets.

2. Health Insurance Plans under commercial auspices have huge "overhead" expenses, not to mention profits. If the administrative expenses of the "voluntary" health insurance industry were at the level proved to be possible in governmental insurance plans, American consumers could save at least a billion dollars a year.

3. Private, solo medical practice is inefficient and extravagant . . . Teamwork clinics . . . could (provide) for lower costs for the patient.

4. The Fee-For-Service system of paying for medical care induces multiplication of services and medically unnecessary procedures. Evidence of unjustified surgical operations is found in most hospitals, especially in small proprietary ones where group medical discipline is lacking.

5. Insurance for in-hospital care . . . induces excessive utilization of expensive facilities.

6. Commercial indemnity insurance for surgical and medical care has led many doctors to raise their fees to higher levels than they would be without insurance. Physicians' incomes have risen much more than those of other occupations and these higher earnings, of course, must come from patients.

Roemer's proposals could be "achieved through careful planning and effective social action." They include: group practice in health centers, with physicians on salary, comprehensive health insurance (governmental) for the entire population, fixed medical fees and "ideally" physicians paid "as other scientists on the basis of their skills, experience and time, instead of on a 'piecework' basis." Finally, "assure full employment and adequate wages, so that a good standard of living can be enjoyed by every family."

The next article is entitled "How Can We Do Better?" Its author, Caldwell B. Esselstyn, M. D., Executive Director of Community Health Association, Detroit, and Chairman of Physicians Committee for





For your tense patient with intestinal spasm,





rescribe improved belladonna therapy with more potent and





onger sustained effect than most synthetic antispasmodics..



Hytrona emphasizes the difference in antispasmodics. This improved therapy contains natural belladonna alkaloids for longer, more potent action. The crystalline alkaloids in Hytrona are carefully weighed to give constant potency. It is well tolerated because the high proportion of hyoscyamine enhances the antispasmodic effect without increasing central stimulant action. Hytrona, in palatable elixir form and easy-to-take tablets, is now available in drug stores in your area.

PRECAUTIONS: Frequent or continued use should be carefully supervised. Discontinue or reduce dosage if dryness of the mouth, rapid pulse, or blurring of vision occurs. Hytrona is contraindicated in glaucoma. Use cautiously in elderly people, especially when urinary retention is present. Phenobarbital may be habit forming.

Hytrona®

Each tablet or 5 ml. teaspoonful represents hyoscyamine hydrobromide, 0.18 mg.; atropine sulfate, 0.015 mg.; scopolamine hydrobromide, 0.005 mg.; phenobarbital 16 mg. (¼ gr.).

PITMAN-MOORE
Division of The Dow Chemical Company, Indianapolis

DOW

Health Care of the Aged Through Social Security.

Esselstyn also describes the jungle (U.S.A.) he's stuck in. Medical care is a matter of pure economics. Infant and maternal mortality among the "have nots" is 400% higher than among the "haves" in this national jungle which ranks 11th in infant mortality in the world. He decries the profit motive in health care. Why? Because "the success of the physician is a measure of the misfortune of the community." Because fee-for-service piece work results in twice as many appendectomies as contract, salaried-physician plans. (Esselstyn, where are the accredited hospitals with 50+% "normal appendix appendectomies"? The Joint Commission will gratefully award you their "Scout of the Year" commendation).

The insurance industry gets its share of flak. "Do we want to see our health dollars spent in this way, with a high proportion of the money going to brokerage fees, commissions, advertising, administration, profits and tax?"

The AMA is not neglected. "Our failure to realize that the AMA's efforts to limit the supply of physicians (by closing medical schools) were not in our best interests, nationally or internationally, has resulted in the present critical low level of supply of physicians." And hear this: "There exists no two-party system, there is no minority leader and no minority report." "One of the greatest of unmet needs today is the support and encouragement of an alternative to the monopoly of the AMA." (Or an alternative to the AFL-CIO, for that matter.)

Esselstyn's solution naturally is comprehensive, group practice, prepayment plans with salaried physicians and control of policy and administration in the hands of the consumer, and preferably "a national health program which will consolidate our existing multiplicity of categories, etc."

The third article, "Here Too—Discrimination!" completes the anti-American Medicine trilogy. Never in the third article are the accomplishments of American physicians commended, nor the service of private physicians acknowledged, nor the fact that physician fees have advanced less than the cost-of-living index mentioned, nor the intransigent stand of the vast majority of physicians against any suggestions of racial bias in hospital staff functions recognized. (In fact the anti-discrimination policies of the AMA would make many alleged trade union policies look sick.)

So this is the gospel being fed labor leaders and union members by members of our profession whose professional responsibility to impartiality and balance has been fogged by their submission to sociologic dogma. It is little wonder that labor leaders react with fanaticism and unreason to the profession that some day will serve each of them—hopefully and assuredly in a different fashion.

In California, implementation of labor's push for eliminating fee-for-service payments and individual practice has provided the rallying issue for resolution of inter-union conflicts. The Council on Alternatives to Health Insurance, headed by Einer Mohn, Director of the Western Conference of Teamsters has been formed to develop union clinics in which salaried physicians will serve union members directly and the employers will make payment directly to the union clinics rather than to an insuring agent. Apparently most of the California unions, including Harry Bridges' International Longshoremen's and Warehouseman's Union have joined.

Says the L. A. Times, "Mohn is regarded as a possible successor to Hoffa, who is now appealing prison terms on charges of jury tampering in a Nashville trial and of fraud in pension fund programs in a Chicago case." Apparently free medicine is Mohn's answer to the challenge of incarceration.

(Continued on Page 336)

to help relieve pain
in common
anorectal disorders

"non-caine"
Diothane®

Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form...both are now available.

DIOTHANE OINTMENT

COMPOSITION:
diperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:
Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.





DIOTHANE SUPPOSITORIES

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

Merrell

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mild arthritic problems

Schering





hen
pirin alone
too little

but
full steroid
is too much

e's a time for as*pirin*—when the pain stiffness are almost bearable and easily rolled.... There's a time for full-dosage *oid*—for limited periods, as in severe ritic flare-up.... And there's often a time moderate formulation of the *two*—when dle-range symptoms, in your judgment, for middle-range therapy. With SIGMAGEN, r arthritic patients get both anti-inflam-tory and analgesic action to relieve ammation, swelling, pain and stiffness.

middle-range therapy with Sigmagen® TABLETS

brand of corticoid-analgesic compound

Each tablet contains 0.75 mg. prednisone, 325 mg. acetylsalicylic acid, 20 mg. ascorbic acid, 75 mg. aluminum hydroxide.

Clinical considerations: Precautions—SIGMAGEN Tablets should be used with the same precautions as other corticosteroids. They should not be used in patients with tuberculosis, peptic ulcer, agitated psychotic states, or herpes simplex of the eye. The physician must be watchful in patients with cardiac decompensation, severe hypertension, diabetes mellitu renal insufficiency, osteoporosis, and marked emotional instability or psychotic tendency. Acute infections must be controlled with appropriate agents. Corticosteroids may mask signs of infection. For more complete details, consult Schering literature available from your Schering Representative or Medical Services Department, Union, N.J. 07083. S-77

UNIONS CHALLENGE

(Continued from Page 333)

Less any condone labors' efforts to control medical practice, look first at the current size of the health, welfare and pension programs across the nation. Today there are $100 billion in reserves. By 1980, the reserves will reach $225 billion. These programs are largely run jointly by union trustees and management. An adamant labor stand will not be off-set by a negotiating management indefinitely.

The only solace physicians can gain from these forecasts is the assurance of any lack of mystery regarding labor's target. It is fee-for-service practice, solo, partnership or group. Ultimately it will turn to all forms of practice exclusive of union and government clinics and hospitals as the ultimate in labor government is approached. We have one long suit. We are the physicians. And as the physicians we alone know what constitutes good practice and good physicians. We still have a chance. We can either blow it with our intransigence and ineptitude; or we can exploit it with a sensitive imagination and resourceful leadership.

THE RUST FOUNDATION ANNOUNCES GIFT TO UNIVERSITY OF ALABAMA MEDICAL CENTER

The Rust Foundation and George M. Rust, Executive Vice President of The Rust Engineering Company, announce the gift of $150,000 to the University of Alabama Medical Center to construct a computer research laboratory and bio-engineering building.

The Building will cost approximately $600,000 with the University of Alabama matching the Rust gift with another $150,000 for a total of $300,000 and will then submit a grant request for an additional $300,000 in matching funds from the National Institutes of Health.

Mr. Rust, in making the announcement, said the Rust Research Center is a gift in memory of his father, E. J. Lee Rust, and his brother, Henry B. Rust, II (known to his friends in Birmingham as Harry).

In accepting the gift, Dr. Joseph F. Volker, Vice President for Health Affairs of the University, said:

"It is becoming increasingly evident that cooperative efforts between the physical and medical sciences are necessary if we are to develop more effective techniques for the diagnosis and treatment of many aspects of disease.

"The generous gifts from the Rust Foundation and Mr. George Rust will make it possible for the University of Alabama to develop within its Medical Center a facility wherein the skills of mathematicians, engineers, physicists, and computer scientists can be applied to health related problems. We are confident that this relationship will be of great benefit to the Medical Center's over-all programs of education, research, and patient care."

According to the architects, the firm of Fuller and Crawford, the building will contain 16,000 square feet and is designed primarily with expansion in mind. It will be a one-floor structure with space for storage and parking on ground level.

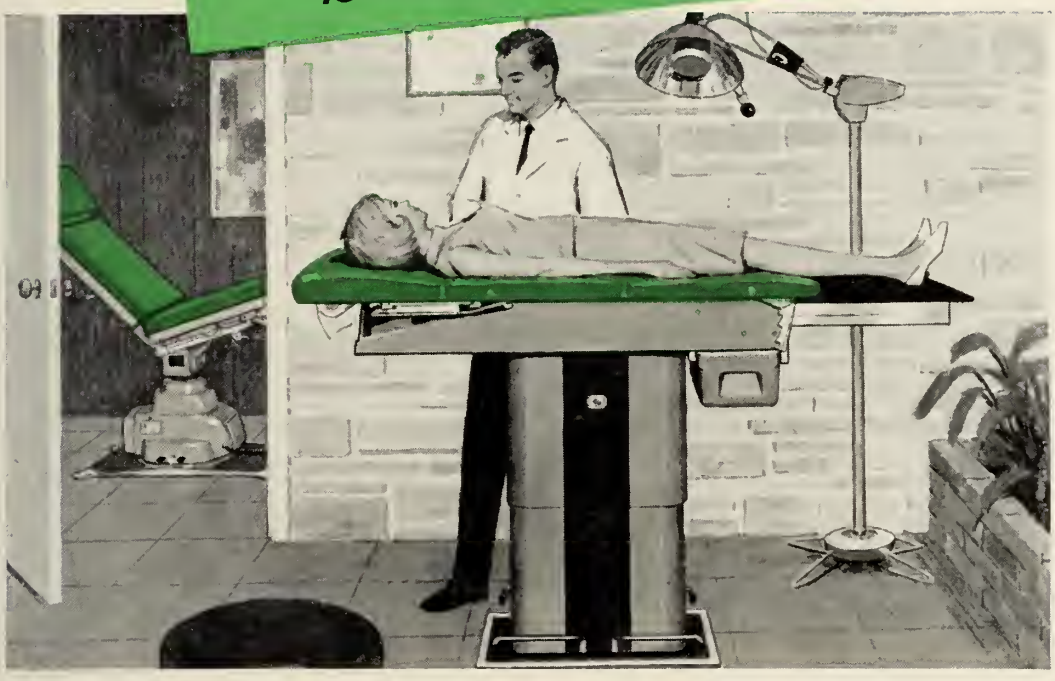
Of contemporary design, the building will ultimately be a four-story building, and can be expanded "out, as well as up." With four stories, it would contain 85,000 square feet.

The main core will be the computer room itself. The remainder of the building will be devoted to teaching space, office facilities for programmers and administrators.

One teaching room will be adjacent to the computer room, with a glass wall for observa-

(Continued on Page 338)

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(Continued from Page 336)

tion of computer activities. Teaching will be programmed to relate to research in the computer field.

One suite of offices is designed for research associates—bio-scientists using an interdisciplinary approach to problems of medicine.

The Rust Engineering Company was organized in Birmingham in 1905 by three brothers, E. J. Lee Rust, S. M. Rust and E. M. Rust. The company has grown steadily through the years until today it represents one of the largest service companies in the industrial construction field, with offices in Birmingham and Pittsburgh, in this country, and in Brussels, London, Paris, Dortmund and Madrid abroad.

"This computer building offers many challenging aspects for our community," said George M. Rust. "I am deeply interested in its development. I, as well as others of the Rust Foundation, feel that it will be a distinctive memorial to my father and brother. My father had an unusually facile mathematical mind and was forever interested in all aspects of the subject. Brother Harry was himself a person of great investigatory ability. His interests ranged a broad spectrum of community and industrial endeavor. His many friends in Birmingham will remember him as always seeking answers on a full range of subjects.

"I myself have a close personal interest in the computer field as it relates to health investigation. We feel sure this center will bring to Birmingham scientific as well as industrial aid."

Both Mr. Rust and medical center officials believe there is a real opportunity for significant progress to be made in cooperative studies between medical researchers and the computer science group.

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An institution for the diagnosis and treatment of psychiatric and neurological illnesses. rest, convalescence, drug and alcohol habituation.

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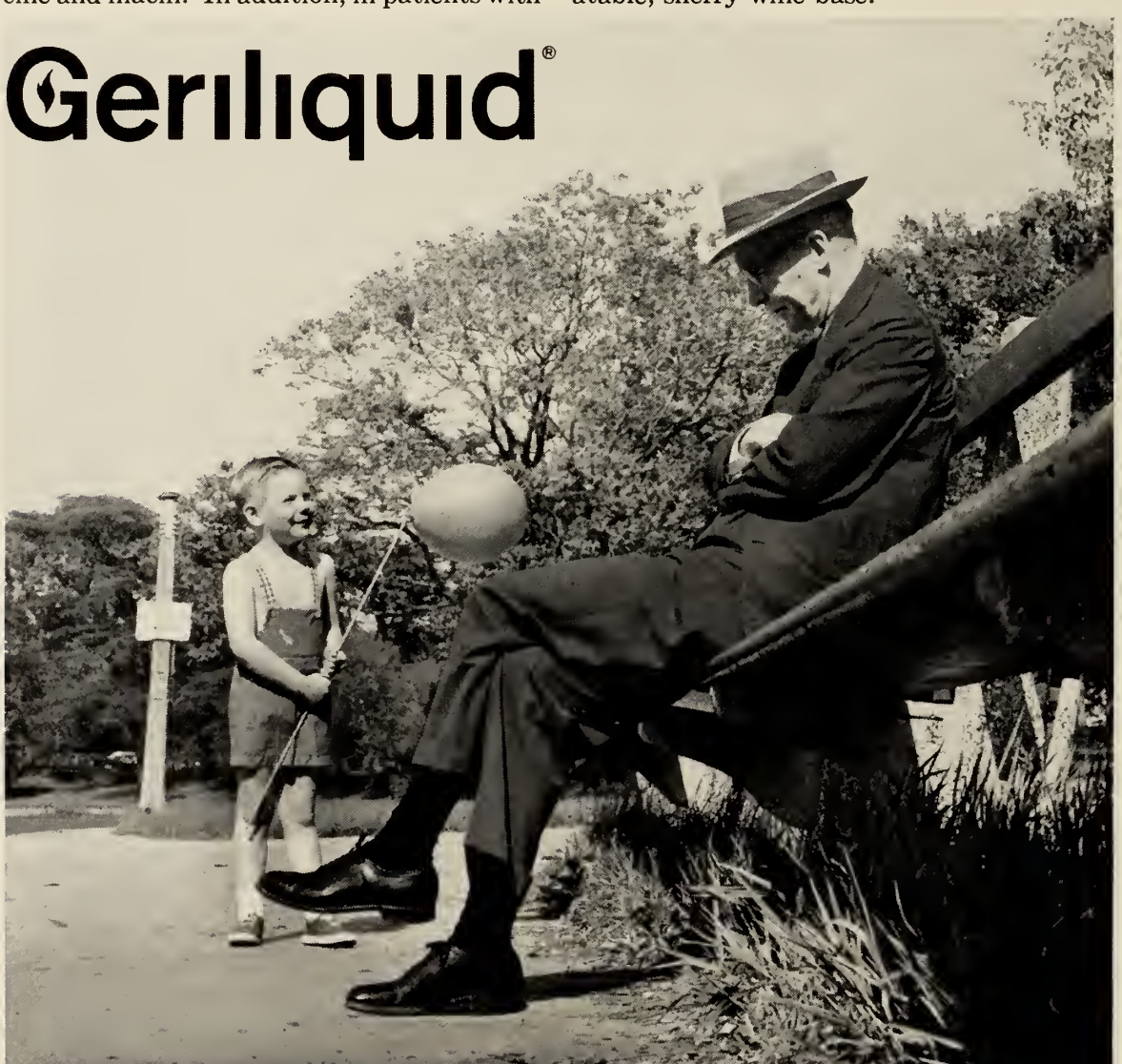
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IN BRIEF: Composition: Each 5 ml. contains: niacin 75 mg. and aminoacetic acid (glycine) 750 mg. in a palatable sherry wine base; alcohol 5%.

Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.

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MATERNAL AND CHILD HEALTH

(First in a Series)

George Cassady, M. D.*

A continuous state-wide Maternal and Infant Health Study is being conducted in Alabama by the Committee on Maternal and Child Health of The Medical Association of the State of Alabama in cooperation with the Alabama Department of Public Health and assisted by official representatives of the various County Medical Societies of the state.

Since the work of the Committee is educational as well as statistical, summaries of some of the cases studied, based on anonymous data submitted, will be published in The Journal of the Medical Association of the State of Alabama *from time to time.*

Hyaline membrane disease is the most important single cause of neonatal death. The origin of the disease is intimately related to the maternal-fetal relationships of pregnancy and its only "cure" at present lies in the prevention of premature labor and its product, the immature infant. It is particularly appropriate, therefore, to begin this new series of articles, whose purpose is to improve maternal and consequently fetal and neonatal health, with this vitally important example of the common ground of obstetrics and pediatrics.

Case Report

Baby boy A was the 2340 gram product of the second pregnancy of a 24 year old white female. The mother's initial pregnancy had resulted in early miscarriage. In spite of adequate prenatal care beginning in the first trimester, premature onset of labor occurred at 35 weeks gestation with subsequent delivery of the immature, low birth weight infant. Cyanosis was evident in the delivery room and on admission to the high-risk nursery cyanosis, grunting respirations, and intercostal and substernal retractions were present. Additional findings included reduced breath sounds bilaterally, absence of audible murmur, normal abdominal examination, and normal neurologic responsiveness. Chest X-ray was diagnostic of hyaline membrane disease and demonstrated diffuse increase in density with a fine, reticular granular pattern apparent when examined under bright light. The disease course was progressive and severe with falling oxygen tension and pH reaching levels of 33 and 6.97 respectively by five hours of age. At that time, the infant was in 50 per cent oxygen—this was subsequently increased to 80 per cent oxygen and bicarbonate in 10 per cent dextrose was administered intravenously in a scalp vein. The infant continued to require between 80 and 95 per cent inspired oxygen for the following 48 hours. During this time, oxygen administration was monitored with arterial oxygen tensions and bicarbonate administration was titrated with arterial pH's. The infant's condition improved at approximately 50 hours of age at which time oxygen tension and pH increased and the infant's activity improved. A drop in hematocrit from 50 to 32 per cent resulting from frequent arterial samples was managed with packed cell transfusion on day two. With improvement in the clinical condi-

(Continued on Page 344)

*Dr. Cassady is in the Department of Pediatrics, University of Alabama Medical Center, and is a member of the Committee on Maternal and Child Health of the Medical Association of the State of Alabama.

"...it is extremely difficult and sometimes impossible to differentiate between 'pure depression' and anxiety and it is questionable whether depression without a certain degree of anxiety really exists."

Lehmann, H. E., Canad. Psychiat. Assn. J. *4(S)*: 1-12, 1959



An antidepressant designed for the clinical realities of office practice

As many physicians have reported, the large majority of neurotic depressed patients suffer from both depression and anxiety. It may be difficult to decide whether these patients are primarily depressed or primarily anxious. And yet drug treatment of only the symptom which seems more prominent may exacerbate the untreated element of the depression complex.

Consequently, it would seem that therapy specifically aimed at both the depression and associated anxiety and tension should increase success in treatment.

This is one of the important reasons why 'Deprol' has proved particularly helpful. For 'Deprol' acts rapidly both to lift the mood and to relieve the associated anxiety, tension and insomnia.

And side effects, at recommended dosage, have been infrequent and generally readily controlled.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

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(Continued from Page 341)

tion, bicarbonate was discontinued but 10 per cent dextrose and water intravenous infusion was continued until adequate oral intake was established. During the infant's recovery, oxygen concentration was maintained at that level necessary to relieve cyanosis. By 90 hours of age, the infant required no additional oxygen and oral intake was well established. Subsequent course has been uncomplicated.

Pathophysiology

The specific cause or primary single event leading to the production of hyaline membrane disease is unknown. Much speculation and considerable experimental animal work suggests intrauterine asphyxia, or more specifically hypoxia, as the important initiating event. Clinical and laboratory results have failed however to establish a conclusive relationship between human perinatal hypoxia (as measured objectively by apgar score and umbilical cord blood gases) and hyaline membrane disease. The single parameter common to all infants with hyaline membrane disease is immaturity. Nearly all infants subsequently developing the disease are gestationally immature, prematurely born infants or are physiologically immature infants of diabetic mothers. Any factor tending to shorten the normal length of pregnancy places the infant at higher risk for development of the disease and the risk of an infant's developing the disease appears to be directly proportional to the degree of immaturity.

The term "hyaline membrane disease" is an unfortunate misnomer. The membranes offer no mechanical block to diffusion of gases and appear to be entirely secondary to the most important physiological and pathological feature of the disease—**progressive, severe atelectasis.** This atelectasis is not, as was previously believed, "failure of expansion"—recent work shows the newborn infant's lung radiologically, physiologically, and chemically well expanded with the initial few breaths. "Primary failure of expansion" is a term that should be reserved for the lungs of still-born, non-breathing fetuses. The progressive atelectasis characteristic of hyaline membrane disease appears intimately related to a deficiency of surface active material ("surfactant") which normally maintains pulmonary stability and allows continuing alveolar expansion during expiration.

Decreased oxygenation and inadequate CO_2 excretion characterizes the clinical course of the disease and reflect the progressive severe atelectasis. Increased "stiffness" of the lung makes the work of respiration more difficult and the increasing intrapleural pressures necessary to expand the stiff lung are reflected in the intercostal and substernal retractions so striking and characteristic in this disease. Increasing hypoxia and hypercapnia in turn produced a severe mixed metabolic and respiratory acidosis. Secondary effects of the hypoxia and acidosis are (1) increased capillary permeability with transudation of extra-cellular fluid into the tissues with resulting edema and (2) increased cellular permeability leading to leakage of potassium from the cells into the extracellular fluid in amounts significant enough to produce life threatening hyperkalemia.

Differential Diagnosis

Accurate clinical diagnosis is a necessary prelude to any attempt at management and the clinician must be alert to the fact that all respiratory distress in neonates is not hyaline membrane disease. The presence of life threatening, potentially curable congenital anomalies must initially be considered. Choanal atresia may produce significant respiratory distress in the neonate and may simply be diagnosed by inability to pass a catheter through the nares into the posterior pharynx. Similarly, the diagnosis of tracheoesophageal fistula must be considered and esophageal patency may be proven by passage of a catheter from nasopharynx into stomach. A third important anomaly, diaphragmatic hernia, is best ruled out by adequate X-ray examination of the chest early in the course of the infant's illness. Pneu-

(Continued on Page 346)

WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: **ACTIONS AND USES:** A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

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(Continued from Page 344)

mothorax and pneumomediastium are important mechanical causes of distress and are frequently misdiagnosed clinically; again, a chest X-ray is essential to diagnosis. Neonatal pneumonitis is generally chemical in origin and represents the inflammatory response of the lungs to aspirated blood or meconium. A perinatal history of intrauterine or delivery-room distress, low apgar, or difficult neonatal resuscitation in a mature infant is characteristic and diagnosis may be further strengthened by demonstration of local areas of increased density on chest X-ray. Prolonged rupture of maternal membranes (greater than 24 hours), prolonged maternal labor, and maternal fever have all been shown to increase the hazard of infection. Prophylactic antibiotics for this condition are to be condemned but intensive culturing of the placenta, membranes, and infant, pathologic examination of the placenta (with immediate frozen section of the umbilical cord searching for perivascular white-cell infiltrations) performed in the early minutes after birth should yield sufficient objective information with which the responsible physician may intelligently choose an appropriate antibiotic to treat a specific infection. The immature infant who has sustained a tentorial tear during delivery or an intraventricular bleed while in the nursery may present with the acute onset of cardio-respiratory collapse and is frequently misdiagnosed as having hyaline membrane disease. Spinal fluid examination is imperative in any immature infant demonstrating severe, prolonged apneic spells, cardio-respiratory collapse and normal chest X-ray. Congenital heart disease and congestive failure may occasionally be present early in the neonatal course and the physician must be alert to this possibility. Early respiratory distress manifested by cyanosis with oxygen dependence, increasing respiratory rate, grunting respirations, flaring alae nasi and intercostal retractions occurring in an immature, gestationally premature, low birth weight infant or in any infant of a diabetic mother should suggest the likelihood of hyaline membrane disease. Confirmation of this diagnosis may be accomplished by demonstration of a characteristic, diffuse increase in lung density on chest X-ray and by the equally characteristic progressive hypoxia, hypercapnia, and acidosis as manifested by blood gas examinations.

Treatment

At the present writing, management of the infant with hyaline membrane disease is entirely supportive. Progressive hypoxia demands **increasing ambient oxygen.** Two particular points need to be stressed in this regard; (1) oxygen is a drug and its administration must be handled as such. Administration of oxygen in "liters per minute" employing wall gauges calibrated in this manner is akin to giving intramuscular drugs by the "syringe-full." Ambient oxygen must be accurately measured as $\%0_2$ in the isolette. (2) Retrolental fibroplasia is the result of hyperoxygenation of the arterial blood. The cyanotic infant, regardless of the concentration of oxygen surrounding him, is poorly oxygenated. Administration of oxygen must not be limited to a magic "40 per cent" in the face of progressive arterial hypoxia and clinical cyanosis. Oxygen should be administered in such amounts as to maintain arterial PO_2 at 60-90 or venous PO_2 at 30-40. This is seldom possible, even with 100 per cent 0_2, during the peak of the disease. On the other hand, the administration of oxygen must be carefully monitored in the recovery phase of hyaline membrane disease and its decrease must be as rapid as clinically feasible.

The cold neonate attempts to restore or maintain normal body temperature by an increase in oxygen consumption. This is obviously harmful in the compromised hypoxic infant with limited oxygen supplies and for this reason **body temperature must be maintained** at 36 to 37° centigrade. **Humidity** of 60 to 70 per cent allows adequate moistening of the oxygen and prevents the drying, dehydrating effects of dry oxygen on the respiratory mucosa. Higher levels of humidity tend only to encourage growth of gram negative bacteria.

Acid-base stability and normal serum potassium are maintained by intravenous infusion with sodium bicarbonate in 10 per cent dextrose and water. The physician employing this treatment should consult the specific references but five to 15 milliequivalents of sodium bicarbonate per 100ml of solution given in amounts of 30-40 ml per kilo per day intravenously generally achieves adequate control. Bicarbonate dosage should depend on serial pH measurements which may be obtained for clinical purposes from capillary blood.

Antibiotics should be used to treat a specific, demonstrable infection. "Prophylactic" or blind use of these drugs is to be condemned.

Additional adjucts of treatment in this syndrome have included assisted ventilation with respirators, aerosolized surface-active agents, parenteral fibrinolytic materials, hyperbaric oxygen, albumin infusion, and digitalis. The potential harmful effects of these various treatments must be carefully considered by the cautious physician in view of complete lack of any conclusive evidences of their value. Of specific importance in this regard is the recently highly publicized use of magnesium sulfate enemas in the management of this disease. It must be pointed out that the reputable medical literature contains no evidences of benefit, considerable words of caution, and a wealth of physiologic information concerning the serious harm this treatment may produce. It seems appropriate in this regard to close this brief summary with the words of Clement Smith, current editor of Pediatrics and author of the definitive text book on new-born physiology: "A major principle in the recommended treatment of any disease of the newborn is the omission of any procedure or drug not of proven value or clear indication."

References

Smith, C. A. Diagnosis and Treatment: hyaline membrane syndrome. Pediatrics 36: 257-260, 1965.

Smith, C. A. Use and misuse of oxygen in the treatment of prematures: Pediatrics 33: 111-112, 1964.

Silverman, W. A. Use and misuse of temperature and humidity in care of the new-born infant. Pediatrics 33: 276-277, 1964.

Cook, C. D. and Cochran, W. D. The respiratory distress syndrome of newborn infants. New England Journal of Medicine. 270: 673-676, 1964.

AWARDS 1965-1966
American Fertility Society

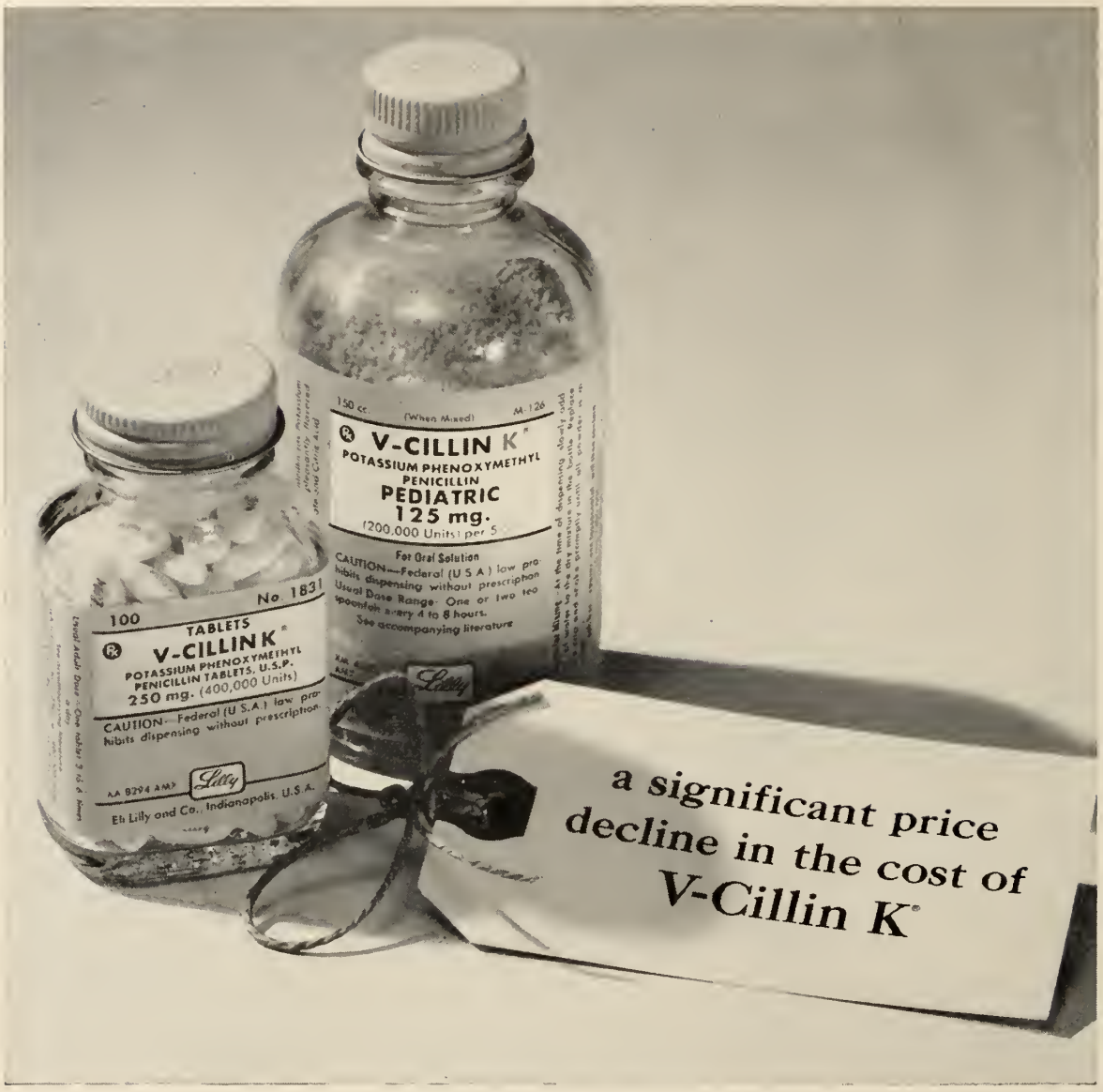
The American Fertility Society announces that the following Awards will be made at its Annual Scientific Meeting at the Drake Hotel, Chicago, Illinois, April 29-May 1, 1966:

I. The Carl G. Hartman Grant-in-Aid, consisting of $750, to be awarded to the Committee's choice of the most promising young man in residency training in obstetrics and gynecology, for the purpose of meeting expenses in attending scientific meetings or visiting clinical and research centers.

II. The I. C. Rubin Award of $250 together with a Certificate of Merit will be awarded to the author of the paper deemed by the Awards Committee to be the most significant contribution appearing in the journal, *Fertility and Sterility,* during the year 1965.

III. The Ortho Medal and $1,000 will be awarded to the Awards Committee's selection of the man who has made the outstanding contribution in the field of fertility and reproductive biology during the years 1963, 1964, and 1965.

Requests for information concerning these Awards should be made to J. George Moore, M. D., Chairman, Awards Committee, 622 West 168th Street, New York, New York 10032.



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New, thin coating . . . new size and shape. The new coating eliminates the characteristically bitter taste of oral penicillin and makes V-Cillin K tablets easy to swallow. The new shape makes them easy for physicians and pharmacists to identify.

Indications: V-Cillin K is an antibiotic useful in the treatment of streptococcus, pneumococcus, and gonococcus infections and infections caused by sensitive strains of staphylococci.

Contraindications and Precautions: Although sensitivity reactions are much less common after oral than after parenteral administration, V-Cillin K should not be administered to patients with a history of allergy to penicillin. As with any antibiotic, observation for overgrowth of nonsusceptible organisms during treatment is important.

Usual Dosage Range: 125 mg. (200,000 units) three times a day to 250 mg. every four hours.

Supplied: Tablets V-Cillin K, 125 or 250 mg., and V-Cillin K, Pediatric, 125 mg. per 5-cc. teaspoonful, in 40, 80, and 150-cc.-size packages.

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Volume 35 November, 1965 No. 5

Intestinal Complications Of Radiation Therapy

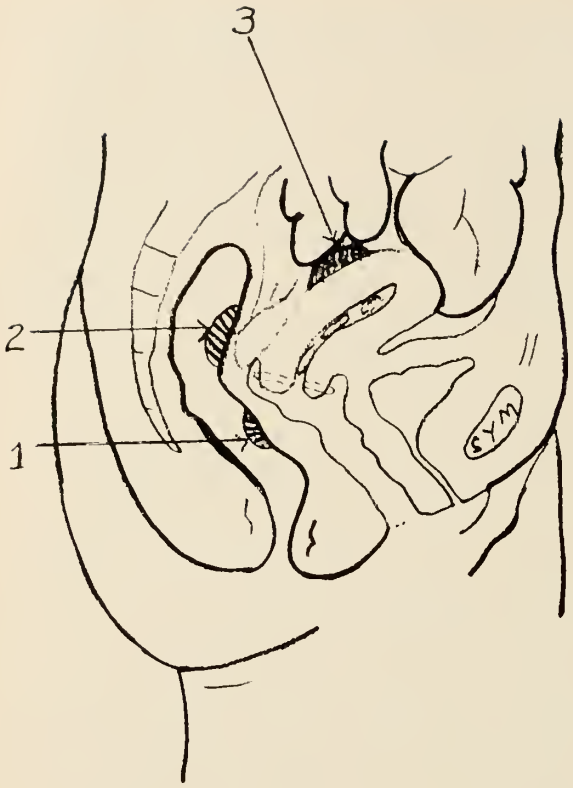
Z. B. Barnes, M. D.

Montgomery, Alabama

Radiation damage to bowel and adjacent pelvic organs receiving therapy for carcinoma of the cervix, vagina or endometrium occasionally presents the surgeon a difficult problem. The complications are those of ulceration with hemorrhage, perforation and obstruction occurring in rectosigmoid or terminal ileum which heals poorly because of arteriolar changes produced by radiation. In reference to history, Futh and Ebeler in 1915 first reported a rectal lesion following irradiation. In 1930 Buie reported 65 cases of irradiation proctitis, and in 1937 Bacon reported 39 cases. Others have made important contributions to the literature and among these are numerous reports of small bowel involvement.[1,2,3,4,5,6,7,8,9,11]

The incidence of some degree of intestinal involvement among large series of cases treated for pelvic cancer varies from 2.1 per cent to 16.9 per cent.[8,11] Graham[7] collected six cases of small intestinal involvement over a period of five years from a series of 1,000 patients irradiated for cancer of the cervix or some other type of gynecological cancer. Wiley and Sugarbaker[3] reported nine cases of small bowel damage among 600 patients receiving irradiation for similar lesions and White and Finn[4] collected 55 cases of late complications with bowel involvement which occurred during a period of 12 years. Colcock and Hume[5] reported 41 patients with radiation injury to the rectosigmoid seen at the Lahey Clinic over a 12-year period.

The total amount of radiation given in most of these cases was at least 4500 R, but all who have written about radiation injury to bowel comment that the amount producing damage is individually variable. It is apparent that the amount of therapy given for cancer is empiric; and since the surgeon and radiologist are treating lethal carcinoma, it is understandable that heavy doses of X-ray and radium therapy are necessarily often given. Unfortunately many patients have been mistakenly treated with both radium and X-ray



Sagital section of female pelvis showing three common sites of radiation injury to bowel.

without full knowledge of past therapy, and with tragic results. However, even with the best available therapy given with judicious control, bowel is sometimes damaged.

The pathologic changes of radiation injury are well known and with respect to intestine have been adequately studied.[10] In response to radiation there is initially an acute inflammatory reaction consisting of edema, hyperemia and infiltration of leucocytes. More important is the injury of arterioles and capillaries which leads to endarteritis, thrombosis and subsequent infarction. The resulting fibrosis, ischemic necrosis and infection produce the intestinal complications. Warren and Whipple[2] with dog experiments showed that the epithelium of the small intestine is remarkably sensitive to X-ray compared with other organs, and that the colon was significantly more resistant to injury than small bowel.

Among patients receiving X-ray therapy for carcinoma of the cervix, the structures most commonly injured are rectosigmoid and terminal ileum. Uncommonly bone injuries may be produced in the neck of the femur and pelvis.[12] The bladder and ureters may be involved. The various stages and sequellae of irradiation proctitis have been well described by Craig and Buie.[9] Among 200 cases of proctitis in their series, 14 developed hemorrhage, obstruction or perforation requiring a surgical procedure. There were four rectovaginal fistulae, ten strictures of the upper rectum or sigmoid, and one case required abdominoperineal resection because of hemorrhage. Wiley and Sugarbaker[3] in a detailed report of nine cases of small bowel involvement noted that seven manifested partial or complete small bowel obstruction involving terminal ileum or bowel fixed in the pelvis by adhesions from surgery prior to radiation therapy. Sudden perforation of ileum or sigmoid is not an infrequent complication presenting a surgical emergency.

The time of onset of an intestinal complication following X-ray therapy may vary from several months to many years later with an average time interval of about two years. This is variable and unpredictable, as is the dosage of radiation. The important point is that a complication such as sudden perforation of bowel may occur years after X-ray therapy was given.

These complications unfortunately occur in patients who have been treated for carcinoma, and the question as to recurrent carcinoma, always arises. The majority of reports have shown that although some have recurrent carcinoma, it is often incidental and not responsible for the complication, and most are free of recurrent tumor. Thus many patients who die from complications of radiation therapy are cured of carcinoma and it is important that attempt be made to salvage these patients.

Case No.	Age	Diagnosis	Therapy	Complication	Treatment of complication	Result
1	57	Endometrial carcinoma	Total hysterectomy; radiation to abdomen and pelvis (2400r to 4 ports)	Radiation fibrosis jejunum and ileum	Laparotomy, lysis of adhesions (unable to resect)	Died of chronic malnutrition due to bowel obstruction 9 months later
2	47	Carcinoma vagina	Local resection. External radiation Intravaginal cobalt, 4050r	Recto-vaginal fistula	Colostomy Fulguration of bleeding granulation at fistula site	Died of infection 1 year later
3	61	Carcinoma cervix	Radium, External cobalt, 4000r 8525r	Radiation proctitis recto-vaginal fistula	Colostomy	Living with no recurrence
4	73	Carcinoma cervix	Radium—dose unknown	Recto-vesico-vaginal fistula	Colostomy Ileal bladder	Living with no recurrence
5	63	Carcinoma cervix	Total hysterectomy; external cobalt, 8000r Pelvic evisceration	Small Bowel fistula	Resection of bowel and fistula	Died of recurrent fistula
6	57	Carcinoma cervix	External cobalt, 4000r radium	Severe radiation proctitis and enteritis	Gastric suction Antibiotics	Living (short follow-up)

Table 1.

Reports in the literature and personal experiences have convinced the author that there is no lesion that taxes the surgeon's judgment and ingenuity as does the problem of the damaged irradiated bowel. These patients are often debilitated, chronically ill, and poor risks for major surgery. The pathologic lesion marked by intense fibrosis, arteriolar changes, and poor tissue healing will defeat an attempt to resect and anastomose unless normal bowel is re-united. Therefore, the surgical approach must be both aggressive and conservative with an unavoidably high mortality rate.

A three-year experience with radiation injuries to bowel among private patients is summarized in *Table 1.* Each of these patients underwent surgery and radiation therapy as treatment for the primary carcinoma at the hands of other physicians, and was referred because of a surgical complication of radiation therapy. One patient (Case 1) presented the complication of such intense and extensive radiation fibrosis of the small bowel that no resection could be done. Three cases of recto-vaginal fistula are included and all required a colostomy. One of these (Case 2) almost exsanguinated from bleeding granulation at the site of the fistula. Fortunately this could be simply managed by fulguration. One patient (Case 4) with a recto-vesico-vaginal fistula and cured of carcinoma has been significantly rehabilitated following construction of an ileal conduit. Three patients died from sequellae of radiation and not from carcinoma.

Summary and Conclusions

Some of the literature concerning radiation injuries to intestine is reviewed and the author's recent experience is briefly summarized. Attention is called to the fact that many patients who die of complications of radiation therapy are cured of carcinoma. Every effort should therefore be made to salvage and rehabilitate these patients.

References

1. Mulligan, R. M.; "The Lesions Produced in the Gastro-intestinal Tract by Irradiation"; Am. J. Path., 18, 515-528; 1942.

2. Warren, S. H. and Whipple, G. H.; "Report of Sensitivity of the Small Intestine to Radiation and the Histological Changes Which Follow"; J. Experimental Med., 35, 203-211; 1955.

3. Wiley, H. M. and Sugarbaker, E. D.; "Roentgeno-therapeutic Changes in the Small Intestine: Surgical Aspects"; Cancer, 3, 629; 1950.

4. White, W. C. and Finn, F. W.: "The Late Complications Following Irradiation of Pelvic Viscera"; Am. J. OB Gyn., 62, 65; 1951.

5. Colcock, B. P. and Hume, A.; "Radiation Injury to the Sigmoid and Rectum"; S G & O, 108, 306; 1959.

6. Abrahamson, R. H.; "Radiation Ileitis"; Arch. Surg., 81, 553; 1960.

7. Graham, J. B. and Villalba, R. J.; "Damage to the Small Intestine by Radiotherapy"; S G & O, 116, 665-668; 1963.

8. Requarth, W. and Roberts, S.; "Intestinal Injuries Following Irradiation of Pelvic Viscera for Malignancy"; Arch. of Surg., 73, 682-688; 1956.

9. Craig, M. S. and Buie, L. A.; "Factitial (Irradiation) Proctitis: A Clinico-pathologic Study of 200 Cases"; Surgery, 25, 472-487; 1949.

10. Bacon, H. E.; "Radiation Proctitis: A Preliminary Report of thirty-nine Cases"; Radiology, 29, 574-577; 1937.

11. Albridge, A. H.; "Intestinal Injuries Resulting from Irradiation Treatment of Uterine Carcinoma"; Am. J. Ob. & Gyn., 44, 833-857; 1942.

AMERICAN COLLEGE OF SURGEONS NAMES NEW FELLOWS

On October 21, 1965, approximately 1,175 surgeons were inducted in Atlantic City as new Fellows (members) of the American College of Surgeons in cap-and-gown ceremonies during the annual five-day Clinical Congress of the world's largest organization of surgeons.

Fellowship, a degree entitling the recipient to the designation "F. A. C. S." following his name, is awarded to those surgeons who fulfill comprehensive requirements of acceptable medical education and advanced training as specialists in one or another of the branches of surgery, and who give evidence of good moral character and ethical practice.

The American College of Surgeons is a scientific, educational and voluntary association of surgeons, numbering 26,000 Fellows in 83 countries. The College was founded in 1913 to improve care of the surgical patient, and has pioneered in many directions in making surgical care as excellent as it is today.

Those receiving this distinction from Alabama at this 1965 Convocation are listed below.

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Sheridan W. Shirley
Edward W. Stevenson

Florence

William S. Bradley, Jr.

Hartselle

James E. Moody

Mobile

Wm. Harold Avant
Charles J. Hollis
Emit L. McCafferty, Jr.

Montgomery

Richard M. Garrett
William H. Chambless

Primary Amyloidosis Of The Bladder

Henry C. Hudson and John O. Tingley

From the Department of Urology, Carraway Methodist Hospital

Birmingham, Alabama

The urinary bladder is not commonly involved by primary localized amyloidosis. In 1961, Kinzel, Harrison and Utz reviewed 16 previously reported cases and five of their own. Four other cases have been reported since 1961. Recently we have encountered a case of primary localized amyloidosis of the bladder which we believe is the 26th case to be reported.

Case Report

The patient, a 59 year old white female, was first seen in the Urology Department, in December 1959. At this time, she complained of burning and frequency of urination for two months duration. Her urinalysis was normal. Suprapubic tenderness was present on examination. Cystoscopy revealed erythema of the urethra but a normal appearing bladder with a capacity of 400 cc's. She was treated with urethral dilatation and instillation of clorpactin into the bladder.

The patient did well until September 1960, when she was seen two weeks after a bout of total hematuria accompanied by severe dysuria and lower abdominal discomfort. Only mild dysuria remained at the time of examination. An intravenous pyelogram was normal and the urinalysis was not remarkable. Cystoscopy revealed a mild urethrotrigonitis, while the remainder of the bladder appeared normal. She was treated by urethral dilatation and bladder instillation of furacin solution.

During the next one and one-half years, the patient had several bouts of total hematuria, treated elsewhere by the instillation of Ag-No_3 into the urethra.

She was seen again in July, 1962, with a history of total hematuria and dysuria for several days. Physical examination, at this time, revealed a harsh systolic murmur over the aortic valve area radiating into the neck. Blood pressure was 180/100 mm Hg, palpable non-tender liver edge and suprapubic tenderness.

Laboratory data at this time showed:

Urinalysis: Loaded with RBC and trace of protein.

WBC: 5700 with 74 polys and 26 lymphocytes.

HEMOGLOBIN: 9.8 gm/100ml blood.

BUN: 27 milligram per cent.

CHEST X-RAY: No abnormality except aortic elongation.

INTRAVENOUS PYELOGRAM: Normal appearing upper urinary tract and a filling defect on the right side of the bladder.

ELECTROCARDIOGRAM: Changes suggestive of old myocardial damage.

CYSTOSCOPY: Revealed erythema of the proximal urethra. A 3 by 3 centimeter raised necrotic lesion was noted on the right side of the bladder adjacent to the right ureteral orifice.

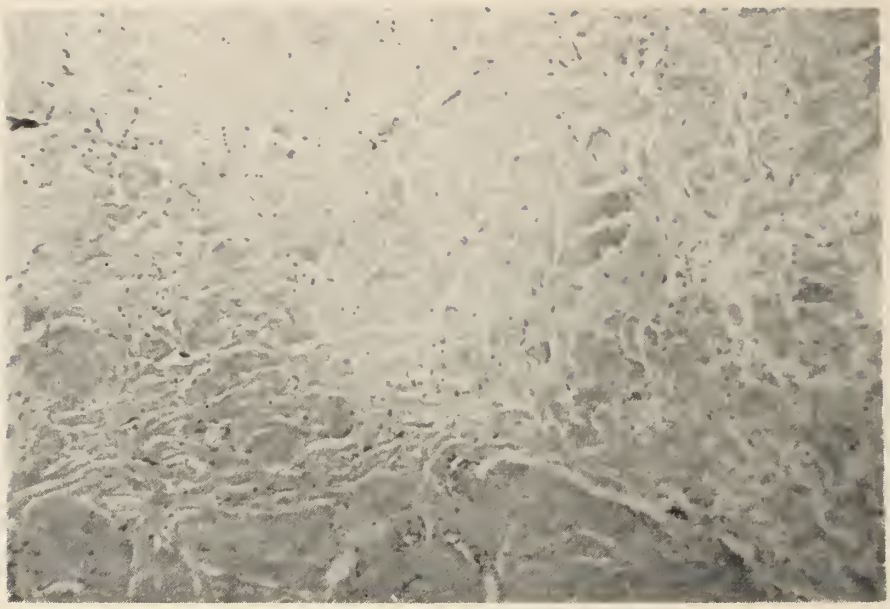


Figure 1. Amyloidosis of bladder wall.

The diagnosis was thought to be a malignancy of the bladder. At laporotomy, a frozen section of the lesion was reported as transitional cell carcinoma, by the pathologist. The lesion appeared to be extensive grossly and seemed to involve the right side of the bladder, the trigone and the urethra. It was elected to do a total cystectomy and urethrectomy and divert the urinary stream with a bilateral uretero-ileocutaneous conduit. At surgery, there was considerable induration extending underneath the trigone into the proximal urethra. There was a cauliflower lesion covering the right ureteral orifice. The post-operative course was uncomplicated and the patient was allowed home on the eighteenth postoperative day, after a congo red infusion test was reported as normal. The permanent section of the bladder wall and proximal urethra was reported by the pathologist (Figure No. 1).

"Beneath an ulcerated mucosa, there were bundles of smooth muscle with edematous interstices. In the submucosa there are focal accumulations of amorphous acellular pink staining material. This amorphous material was also present in the walls of the small blood vessels of the bladder wall. Staining with congo red identified this material as amyloid. In some areas, multinucleated giant cells of Langerhans' type were observed embedded in the amorphous material."

The patient had no urinary complaints for two years postoperatively. During this time she did require constant therapy for congestive heart failure. She expired in May of 1964, of heart failure. Postmortem findings revealed no deposits of amyloid in any organs. The cause of her congestive heart failure and subsequent death was due to widespread arteriosclerosis with myocardial damage.

Discussion

This case was mistakenly diagnosed as a malignancy both pre-operatively and by frozen section examined histologically at the time of surgery. As pointed out by Kinzel et al, in his excellent review, most authors have described the lesion as similar to an infiltrating neoplasm.

The disease has no characteristic symptoms or findings to suggest the diagnosis without microscopic study. Painless hematuria is the most commonly encountered complaint. Bladder irritability is apparently found only if there is superimposed infection. The upper tract is normal unless there is ureteral orifice involvement.

The previously reported cases have been successfully treated by segmental resection of the lesion, transurethral resection of the lesion, electrocoagulation and, in one other case than ours, by total cystectomy. Recurrence of the disease has apparently not been a problem, except in one of Kinzel's cases and possibly one other. The prognosis of the disease is good.

Summary

A case of primary localized amyloidosis of the urinary bladder is reported. The patient had a total cystectomy on the basis of pathological findings in a frozen section done at surgery, mimicking transitional cell carcinoma of the bladder.

References

1. Kinzel, R. C., Harrison, E. G. and Utz, D. C. Primary Localized Amyloidosis of the Bladder. Journal of Urology 85 (5) 785 May 1961.

2. Nagel, R. Localized Amyloidosis of the Bladder. Journal of Urology 88: 56, July 1962.

3. Houtappel, H. C. and Lawvers, G. I. Primary Amyloidosis of the Bladder. Arch. Chir. Neerl. 12-308, 1960.

4. Werner, H. A Primary Tumor like Amyloid of the Urinary Bladder. Z. Urology 54: 61, February 1961.

5. Grace, Donald A. and Kenneth N. Walton. Primary Localized Amyloidosis of the Bladder. Journal of Urology 92: 6, December 1964.

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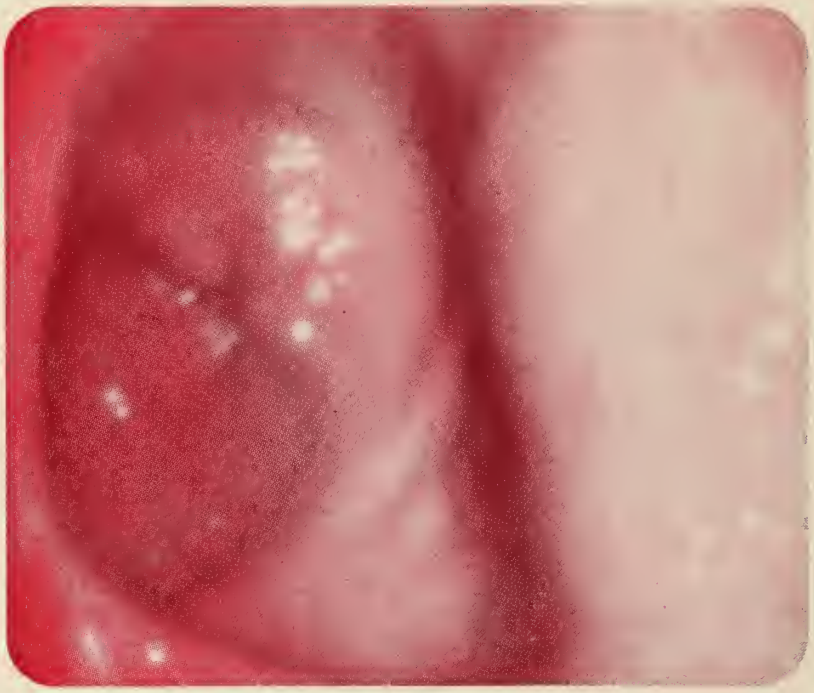
STATE OF ALABAMA

APRIL 21, 22, 23, 1966

MOBILE, ALABAMA

Please send request to Executive Secretary, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama 36104.

Intragastric photography studies[1]



A/ E. B., male, age 48. Normal antral contraction. Pyloric opening is not seen. It is difficult to differentiate a deep prepyloric contraction from a "pyloric fleurette" or true pylorus.

B/Same subject after 6 mg. of propantheline bromide intravenously; antral contractions ceased. The pyloric orifice remained open and was easily identified. Better visualization of the antrum was also obtained.



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In addition to the intragastric photographs, cinegastroscopic studies[2] have demonstrated graphically not only its effectiveness but the superiority of Pro-Banthine over belladonna alkaloids.

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Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

1. Barowsky, H.; Greene, L., and Bennett, R.: Investigators' Clinical Report. Photographs courtesy of Drs. H. Barowsky, L. Greene and R. Bennett.

2. Barowsky, H.; Greene, L., and Paulo, D.: Paper read at Meeting of American Society for Gastrointestinal Endoscopy, Montreal, Canada, May 25-27, 1965.

SEARLE

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Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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How the Social Security Law Now Affects Physicians

EDITOR'S NOTE: *We suggest physicians clip and file the following information that describes the benefits now available to physicians under the Social Security laws. We are indebted to the A.M.A. News for this information. As the recent President's Page indicated, all physicians—either self-employed or on salary—are now covered under the law. First payments into the SS fund are due in April 1966. In addition to the information here presented we highly recommend two other current articles on the subject; Medical World News, Sept. 10, 1965, pp. 111 and Medical Economics, Sept. 6, 1965, pp. 88.*

Mandatory inclusion of self-employed physicians in the Social Security System means that for the first time many physicians will need to know what the program demands from the taxpayer and what the taxpayer can expect in benefits from the program.

The most immediate effect of the newly-enacted law is that physicians previously excluded from coverage under the Social Security System will now begin paying social security taxes. Because of the relatively high average earnings of physicians, most will pay the maximum amount.

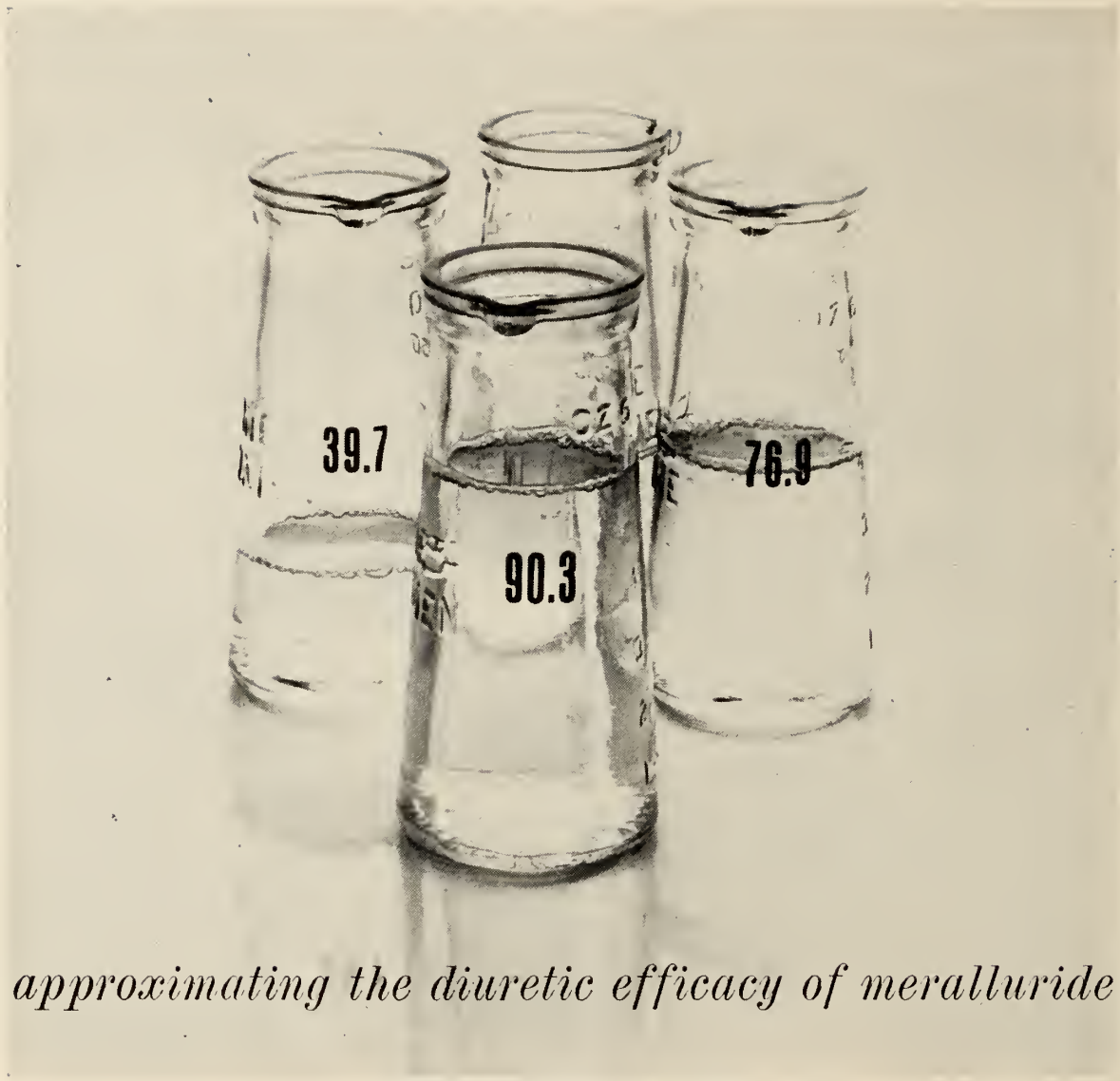
Dates for Benefits: As for benefits, physicians who became 65 on Jan. 1, 1965, and who have never performed work covered by social security law, will not be entitled to full benefits of the program until at least July 1, 1968. Limited benefits could be available by April 1, 1966.

The Social Security Administration estimates that "about half" of the nation's self-employed physicians have, at some time, performed work that was covered by social security law, and may already have social security credit for that work.

In addition, according to SSA, physicians who were in military service between Sept. 15, 1940, and Dec. 31, 1956, may receive social security credit for active duty, unless that duty tour is being counted toward certain other federal benefits. Military service after 1956 is covered by the law in the same way as other kinds of employment.

First Tax Payment: The tax "bite" on self-employed physicians for 1965 will be $259.20 on the first $4,800 of earned income, and it will be payable by next April. In 1966, the

(Continued on Page 361)



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To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin® (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

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IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

(Continued from Page 359)

tax will be applicable to the first $6,600 of earned income and will total $405.90.

Barring changes by Congress, the maximum earned income base will remain at $6,600 in succeeding years while tax rates will be increased so that physicians earning $6,600 or more will pay $422.40 in 1967-68 and will eventually pay a top of $514.80 in 1987.

Physicians who are employed on a full-time salaried basis will see their social security taxes rise from the $174 they will pay this year to $372.90 in 1987. An equivalent amount will be contributed by their employers.

Schedule SE To Be Filed: According to the SSA, self-employed MDs will now be required to complete Schedule SE when filing 1965 income tax returns. The 1965 social security tax is payable at the same time as the 1965 income tax.

The SSA said social security payments may be incorporated into quarterly estimate payments which the physician makes on his income tax.

Benefits available under social security include retirement, survivors', disability and medical, and are based on a taxable wage base of $6,600 a year.

Maximum Benefits: Assuming that most physicians have annual incomes above $6,600, they would be eligible for the maximum benefits available. For example, a doctor retiring at age 65 will be entitled to a lifetime monthly benefit of $168.

If he is married, the monthly benefit could be as much as $252, and if his wife is 65 or over, she is entitled to an amount equivalent to 50% of the husband's monthly benefit. Beneficiaries between ages 62 and 65 can elect to take a reduced monthly benefit, which will be payable for life.

Physicians who wish to maintain a small practice after "retirement" may earn $1,500 in any year without sacrificing any of the maximum benefits due them. Benefits are reduced, however, by 50¢ for every dollar earned between the levels of $1,500 and $2,700—and for every dollar earned in excess of $2,700, there is a dollar for dollar reduction in benefits. After age 72, maximum benefits are payable regardless of income.

Monthly Income Figured: The American Medical Association's Department of Economics pointed out that regardless of total annual earnings, the social security benefit is payable in any month in which earnings are less than $125, or in which "substantial services" are not performed.

Survivors' benefits available under social security are intended to provide a base of protection which can be supplemented through other sources for the physician's family.

Under present law, full survivors' benefits are available to a widow at age 60, and are payable to a widow of any age if there are dependent children surviving under age 18 (or 22 if the children are in school).

Widow's Benefits: A maximum benefit of $138.60 per month for life is payable to the widow without dependent children. The benefit is increased to $252 if there is one dependent child, and to $368 with two or more children.

Benefits for a widow cease when the children reach 18 (or 22 if in school) and do not resume until she reaches age 62—or age 60 if she elects to take reduced benefits at that time. Finally, there is a nominal lump-sum death benefit of $255, payable upon the death of a covered worker.

Disability benefits, when available, are payable to the worker and his dependents, with the same dollar amounts involved—from $168 for the worker alone up to $368 with two or more dependents.

Insured Status: Payment of any benefits under social security depends upon the insured status of the worker—whether he is "currently insured" or "fully insured."

Eligibility for most benefits requires "fully insured" status, which may be acquired by 40 quarters of coverage earned any time after 1936.

(Continued on Page 362)

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Second Method: A second way to achieve the "fully insured" status is to have at least one quarter of coverage for every four quarters elapsing after 1950—or age 21, if later—and before age 65.

AMA's Department of Economics pointed out that since the above provision was not amended in the new law to reflect the fact that self-employed physicians were not covered before Jan. 1, 1965, there will be a period in which many doctors will be unable to receive benefits.

(The term "quarters of coverage" refers to periods of three calendar months each ending on March 31, June 30, Sept. 30, or Dec. 31, during which a specified minimum amount of wages or self-employment income must be credited in order to receive insured status credit for that period. For the self-employed, credit is earned for each quarter in which self-employment net income for the year is at least $400).

To become "currently insured," an individual must acquire a minimum of six quarters of coverage during the 13-quarter period ending with:

- **The quarter in which he first became eligible for benefits.**
- **The quarter in which he actually retired.**
- **The quarter in which he died.**

1966 Date: Under these provisions, a self-employed physician cannot qualify for benefits available under "currently insured" status until at least April 1, 1966.

An individual must have "fully insured" status to qualify for retirement benefits. Survivors' benefits are available to persons either "fully insured" or "currently insured," while "fully insured" status, plus at least 20 quarters of coverage out of the last 40 quarters prior to a disability, are required for disability benefits. Medical benefits are available to all persons 65 and over.

Being insured, the SSA noted, means only that an individual is eligible for benefits but does not determine the amount of the monthly benefit payable to the insured or his family. That amount depends upon one's average earnings under social security. The insured individual need not be concerned with this detail, however, since the SSA will always calculate the benefits using those years which will produce the highest benefit.

Finally, it is important to remember that eligible persons must file for benefits with the nearest SSA office. Failure to do so may result in forfeitures of some benefits, although the Social Security Act grants retroactive benefits for up to 12 months.

Health Sciences Research Building University of Alabama Under Construction

The new addition to the Health Sciences Research Building of the University of Alabama Medical Center is presently under construction. Contract for the construction was awarded to Robins Engineering Company of Birmingham. The $1,200,000 structure will contain eight floors and a basement, and will add approximately 42,800 square feet of space to the present building. The completion of this building and the Veterans Administration Research Bridge, which is presently under construction, will add 75,000 square feet of research area for Medical Center investigators, making a total of approximately 220,000 square feet of space devoted to research in the health sciences.

Funds for the newest research structure were made available by the State bond issue awarded to the University, plus an equal amount from the Health Research Facilities Division of the National Institutes of Health.

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In Brief: Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery. Contraindications are complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.
Supplied: Metatensin tablets, 2 mg., 4 mg. — bottles of 100 and 1000.

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PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. Further information is available from the central office, 19 South Jackson Street, Montgomery, Alabama 36104—or Phone 263-6441.

LOCATIONS WANTED

GP—grad. La. State Univ. 1962; age 35; Protestant; married. Interested in Huntsville or northern Ala. Army oblig. completed. Seeking association. Ala. Lic. Available immediately LW-13

Pediatrician seeking location, group or associate, Allergies spec.; age 29; married; Protestant. Univ. of Tenn. 1961; Board eligible. Military obg. completed. Available Jan. 1966 LW-14

Pediatrics-Cardiology: age 34; Protestant; Med. Col. of Ga. 1955; Certified Am. Boards; Military obg. completed. Seeking solo, group, or associate. Available Immed. LW-15

Pediatrics-Cardiology, age 45; Protestant; Med. School Toronto 1952; Elig. Am. Boards; Seeking group, associate, or instit. LW-16

Orthopedist, age 32, Protestant, Tulane Univ. 1958; Married; Seeking location in group or association. LW-17

Ophthalmologist, age 32; Protestant; Univ. of Tenn. 1958; Board Eligible; Married. Seeking location in group or association. LW-18

Anesthesiologist, age 37, protestant, Univ. of Glasgow 1952; Elig. Am. Boards; Military obg. completed; Married. Seeking location instit. or group. LW-19

Ob-Gyn, age 33, Jewish; Univ. of N. Y. 1957; Board eligible; married. Military obg. completed; Elig. Am. Boards; Available immediately. LW-20

GP with Ob-Gyn emphasis; age 42, Protestant; Med. Coll. of Ala. 1949; Elig. Am. Boards, seeking solo practice or with group. Prefer 75 mi. of large city facilities. LW-21

PHYSICIANS WANTED

GP-Internist-Surgeon wanted in north central part of state in town of 3,000+. Hospital of 25-beds, modern 4-doctor clinic. Schools excellent and fully accredited; many churches; survey shows high doctor-income potential. Near extensive lake areas. PW-7

GP-Internist—for town in eastern part of state. Modern clinic available; nice housing; county high school and many churches. Income is from plants including lumber, pulp and wood industry, oak flooring and casket company. Recreational and social activities good. Trade area around 18,000. Town 1,000. PW-8

GP needed to be associated with two well-established doctors in S. Ala. town of 3,500. Trade area 2,000. Excellent schools, 13 churches. Only 35 miles from Gulf of Mexico with beautiful beaches and recreational facilities. Fully equipped office adjacent to 60-bed hospital. Full staff privileges. PW-9

GP needed for town in NE part of state. Pop. 5,000 in fast-growing industrial area. Two hospitals and large medical clinic. New nursing home. Staff open. Modern schools fully accredited. Nearby lake areas. PW-11

S. Ala. town 3,500, 10,000 trade area in dire need of physicians for GP and Surgery. Two hospitals—one entirely new locally owned with 30 beds, air-conditioned, fully equipped. Open staff. Economic stability governed by textile mills, tung and peanut oil, paper and pulp wood industry, Air Force payroll. Textile Corp. guarantees monthly stipend, free office space adjacent to new hospital for 6 months. PW-10

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by getting away from frigid weather



. . . but if your patient can't get away, relieve sneezing, running nose, and congestion of colds and sinusitis all day or all night with one

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needed by suburban middle Tennessee group. Salary $18,000 to start, leading to full associate status in one year. Full out-patient facilities available, near hospitals and universities, American born. Call Business Manager 615—883-2331 or write *The Journal of the Medical Association of the State of Alabama.*

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Indications: Many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

*Dorhout Mees,E.J.,and Geyskes, G.G.: Acta med.scandinav. 175:703,1964.

Photos: A 59-year-old woman with hypertensive cardiovascular disease and edema resistant to low-salt diet and bed rest. The patient lost 8½ lbs. in one week with a single tablet daily of Hygroton, brand of chlorthalidone.

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Legal Pains For The Healing Arts

(Law For Doctors)

by Carl Ray Robinson, A. B., M. D., J. D., F. A. C. L. M.

Two Volumes 2750 pp., Medico Legal Publishing Co.

It has recently been my pleasure to review the above mentioned set of books. As the title implies and the content of the books most adequately demonstrates, this is truly the "Law For Doctors." As a practicing physician for a number of years, the author is well acquainted, first hand with the medico-legal problems of physicians, paramedical personnel and institutions. In addition to the author's credentials and experience as a physician, he is also a licensed attorney at law and as such has been able to compile from his biprofessional knowledge, an outstanding service both to the medical and paramedical fields. Despite the fact that the books were intended primarily as an aid to the medical profession, it could not be considered as a lay work by attorneys or physicians.

This set of books is unique in that it is a comprehensive compilation of medico-legal cases from the appellate courts from throughout the United States, dealing with every sort of litigated case of medico-legal interest. In this format, the author has presented the facts and points of conflict in each case which the courts were called on to decide. Thus, the reader may easily place himself in touch with factual situations and the law covering such situations which may be of interest to him.

Interestingly enough, this presentation by case book is the method used by most law schools in training attorneys throughout the United States. For this reason, the physician may read, interpret and approach each case just as an attorney might do. This is possible because of the author's ability to integrate medico-legal material which might otherwise be confusing legal concepts to physician. This has been done by deleting technical procedural aspects from the cases.

The table of contents Part I deals with malpractice cases. One glance at the section will quickly bring the reader face to face with almost every legal pitfall which has reached the highest courts of the country. Here the reader may easily locate each subject and the law in point and in the words used by the Court in deciding the case and the reasons for doing so.

Part I covers such topics heard frequently today by physicians as Abandonment, Negligence, Res Ipsa Loquitur, Consent and Drug Allergy Cases. Out of such cases arise actions by individuals for damages against physicians and other paramedical personnel and institutions. Such actions are usually based on contractual obligations or negligent conduct with resultant injury to a person (called in law, torts or wrongs).

Part II covers criminal offenses and begins with cases involving offenses against the state or federal governments in contrast to cases found in Part II which deal as noted above with personal causes of action. Topics such as Manslaughter, Abortion, Harmful Drugs and Narcotics as well as Statutory Rape are covered under this section.

Part III deals with other problems of the practitioner not falling strictly within the scope of Parts I and II. Here such topics as the law of evidence, Privileged Communication, Insurance, Hospital Privileges, Tax Situations, Regulations of Practice, to name only a few.

In my opinion the author has covered and brought together in the most useful manner, selected cases and the law covering the entire spectrum of medico-legal problems which the medical profession faces every day.

Nearly every medical periodical today contains random cases of medico-legal interest, thus pointing up the problem and the need for a compilation such as Dr. Robinson has brought together. If the physician can avoid but one legal pitfall by availing himself of the information and experience of others, I am sure that the price of this set of books would be considered a wise investment.

As a practicing physician and attorney, and therefore being personally familiar with the growing legal problems of medical practice, I can wholeheartedly recommend this excellent set of books to physicians and as a treatise on the law to attorneys.

Thomas L. Smith, Jr., B. S., LL.B., M. D.

* * *

These two volumes on the past records of Medico-legal cases have been specifically compiled by a physician for physicians. The cases are presented in such a way that each one enlightens the physician as to the legal pitfalls in the everyday practice of medicine in general as well as the various specialties within the medical field. In so far as I am aware, there is no other comparable work which has, as the basis for its compilation, the interest of the physician so pointedly brought to light.

In addition to all the recent cases, which represent actual decisions of appellate courts throughout the United States, supplements will be compiled by Dr. Robinson as additional cases accrue.

Cases are so arranged that quick reference is available dealing with malpractice, criminal offenses, physician-patient relationship, insurance, hospital privileges, workmen's compensation, libel and slander, the regulation of practice and other problems encountered by a practicing physician. The Table of Contents and Index allow the physician to easily locate cases dealing with his specific interests. The cases are succinct and spare the physician the discussions of technical procedural questions.

In as much as the Medico-legal aspects of the practice of medicine are becoming more and more prominent, it would seem that all physicians should familiarize themselves with the laws regarding their liabilities. This set of books makes such an awesome task a rather pleasant and interesting way of acquiring an up-to-date knowledge of the Medico-legal field.

Dr. Robinson is one of the few physicians in the United States who is actively engaged in the practice of medicine and holds a Juris Doctor degree in law and is a member of the bar. He is to be highly commended for the great effort required to compile, edit and index these two volumes specifically for the enlightenment of other practicing physicians. A set of these books should be a part of the physician's library.

Oliver C. Baker, M. D.

* * *

This set of books is unique in that it is composed of two casebooks compiled specifically for doctors. It is to be contrasted with other works in the medico-legal field, written principally for the lawyer's benefit. As the title indicates, the contents of the set is concerned with law for doctors, rather than medicine for lawyers.

All cases included are actual decisions of appellate courts throughout the United States. They are all recent, and, consequently, deal with legal questions of current interest. Each case is directly related to some phase of that area called the "healing arts."

The editing of the cases indicates that the interest of the doctor was foremost in the mind of the author. Most of the discussions of technical procedural questions by the courts have been stricken from the cases.

The arrangement of the cases included should also be helpful to the doctor. Part I of the set is made up of cases in which the doctor has been sued for malpractice. This

(Continued on Page 371)

a rapid lift from the hell of depression



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(desipramine hydrochloride)

Norpramin is a rapid-acting specific drug for the treatment of depression. Depressive signs and symptoms—sometimes described as "mental pain"—typically begin to improve in 2-5 days. Patients are more hopeful, less empty and less weighed down by their troubles. Norpramin has only slight sedative qualities, nevertheless anxiety *secondary to depression* is frequently relieved as depression is lifted. If anxiety or tension persists it can be controlled by adding a tranquilizer or by reducing dosage. Norpramin is not a MAO inhibitor. Side effects are usually mild.

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Supplied: Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

LEGAL PAINS FOR THE HEALING ARTS

(Continued from Page 369)

part is divided into sections pertaining to specific acts of malpractice—from "Abandonment" to "Incompatible Blood, Drug Allergies and Injuries." Part II contains cases dealing with criminal offenses from abortion to the unlawful practice of medicine. Part III deals with a variety of other problems of the practitioner and includes cases pertaining to the physician-patient relationship, insurance, hospital privileges, workmen's compensation, libel and slander, regulation of practice and others.

The work is complete with Table of Contents and Index to assist the busy doctor in locating a case or a matter in which he has a special interest.

Compiling, editing and indexing a casebook of this magnitude was certainly a tremendous task and an accomplishment for the author. Each case is surely of interest to the doctor. A reading of a few of them should make the practitioner aware of the many legal pitfalls which he encounters in his everyday practice. The work should also acquaint the doctor with some of the problems of the lawyer in the medico-legal field and, thus, create better relations between the two professions.

The author is one of the very few medical doctors in the entire nation who also has a Juris Doctor degree in law and is a member of the Bar. He produced a commendable work that should be of interest to the lawyer and that should be found in every doctor's library.

Arthur A. Weeks

Dean, Cumberland School of Law

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A survey two years ago showed that 60 per cent of American children one to four years old had not completed standard diphtheria, whooping cough and tetanus immunization; 40 per cent had not been vaccinated against smallpox and 32 per cent had not been immunized adequately against polio.

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All of them, possibly.

Patients approaching middle age, as well as pregnant women who complain of constipation, belching, and flatulence, with no evidence of organic disease may be suffering from functional disturbance of the biliary tract.

Often, these basic disturbances can be corrected by a single convenient and effective medication: Neocholan.

Neocholan is more than a laxative. It combines all the ingredients for the total management of functional biliary stasis in one tablet. Dehydrocholic acid stimulates the production of thin, free-flowing bile. Bile salts promote better digestion to absorb fats and fat-soluble vitamins, and they tend to prevent chronic constipation by maintaining intestinal tone and normal peristalsis. Phenobarbital and homatropine methyl bromide relax intestinal spasm and insure unobstructed passage of bile and pancreatic juice into the duodenum.

Neocholan is contraindicated in patients with glaucoma. Use cautiously in elderly patients with urinary retention and reduce dosage if blurring of vision, increase in pulse rate, or distressing dryness of the mouth result.

Each tablet contains Dehydrocholic Acid: 250 mg. (3¾ gr.); Bile Extract (Porcine): 15 mg. (¼ gr.); Phenobarbital: 8.0 mg. (⅛ gr.) (Warning: May be habit forming); Homatropine Methyl Bromide: 1.2 mg. (1/50 gr.).

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Look, Doctor, what he needs is a shot of penicillin.

Maybe. Maybe not. In any case, he needs something to control his cough.

If it's the useless, exhausting type of cough that often accompanies respiratory infection or allergy, you can provide prompt relief with Novahistine DH. Its decongestant-antitussive action controls frequency and intensity of cough spasms without abolishing cough reflex. And the fresh, grape flavor of Novahistine DH appeals to children and adults alike.

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Each 5 ml. teaspoonful of Novahistine DH contains phenylephrine hydrochloride, 10 mg., chlorpheniramine maleate, 2 mg., codeine phosphate, 10 mg. (Warning: may be habit forming), chloroform (approx.), 13.5 mg., l-menthol, 1 mg., Alcohol 5%. Each 5 ml. of Novahistine Expectorant contains the above ingredients and, in addition, glyceryl guaiacolate, 100 mg.

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Individual Physician Compliance With Title VI

Of The

Civil Rights Act Of 1964

The Department of Health, Education and Welfare requires the Administering Agency in each state, usually the State Department of Health or the State Department of Welfare, to sign a Statement of Compliance with Title VI of the Civil Rights Act of 1964 in order to be eligible for federal funds used in many of the medical programs of each state. If such state agencies are required to sign such a compliance, they in turn must guarantee the compliance of the individual vendors of service, either hospitals or physicians. This has led to the policy in some states such as Ohio and Louisiana of compliance forms being sent to physicians for their signature as a pledge not to discriminate because of race, color, or national origin. Such compliance pledges have aroused a storm of protest from physicians all over the country. It is well known that physicians have always rendered service to individuals according to their medical needs without discrimination because of race, color, or national origin. For this reason, physicians have considered it to be altogether unfitting for the Department of Health, Education and Welfare to require such pledges from physicians to continue to serve recipients of needed medical care. Such protests have been represented to the Department of Health, Education and Welfare by the American Medical Association and by the Louisiana State Medical Society among others.

According to the latest information from the American Medical Association, transmitted in a copy of a letter from the Department of Health, Education and Welfare, it will not be necessary for physicians to sign any type of compliance pledge. It is to be presumed, however, that physicians will continue to render service to all individuals without discrimination on the ground of race, color or national origin. A statement of this requirement of the law will be placed on the vouchers or other claims forms, not for signature as a pledge by the physician, but simply as a notice of the legal requirement for the information of the physician or hospital "vendor" or for information of the recipient (patient).

> NOTICE: The _____ Department of Public Welfare has assured compliance with DHEW Regulation, Title 45, Code of the Federal Regulations, Part 80, which implements Public Law 83-352, Civil Rights Act of 1964, Section 601, of which states: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." Under these requirements payment cannot be made to medical vendors providing care and service under Federally-assisted programs conducted by the Department of Public Welfare unless such care and service is provided without discrimination on the grounds of race, color, or national origin. Written complaints of noncompliance should be made to the Director of Public Welfare, _____, or the Secretary of Health, Education, and Welfare, Washington, D. C., or both.

If a complaint of non-compliance is registered with the Secretary of Health, Education and Welfare, payments to the vendors will be suspended until such complaint is withdrawn after investigation.

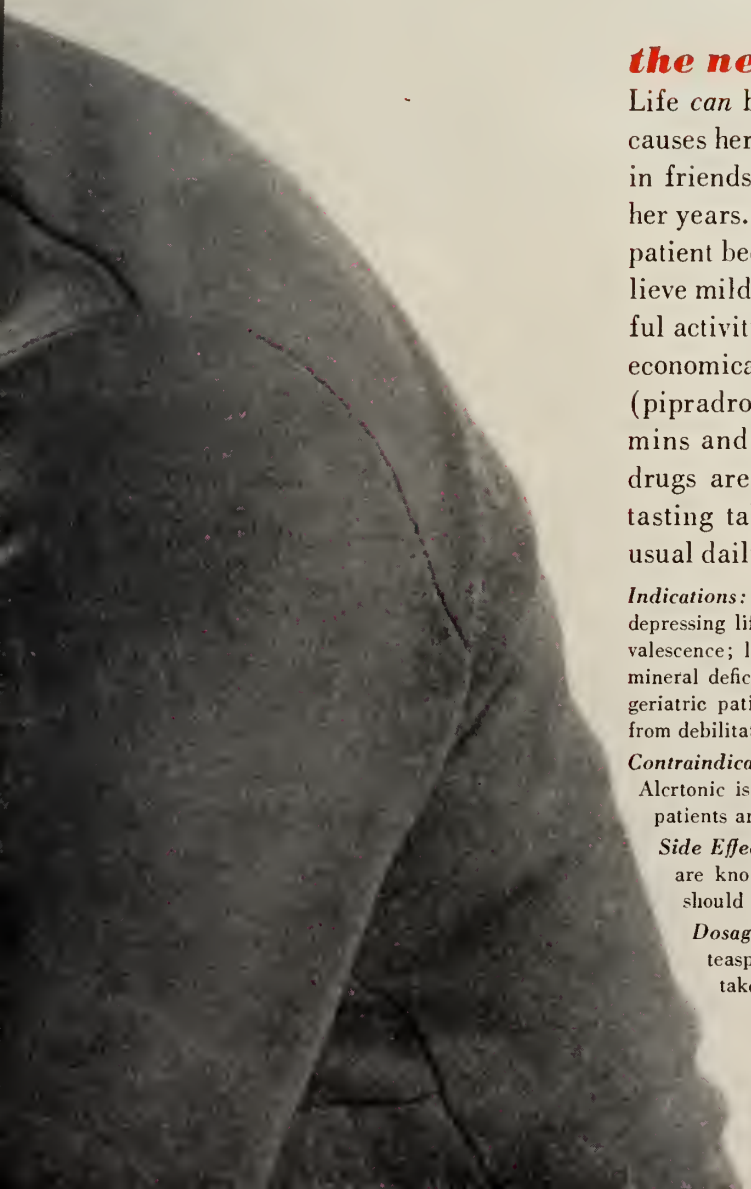
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*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.



the need for a tonic knows no age

Life *can* begin at forty—except when functional fatigue causes her to feel tired all the time; to start losing interest in friends and surroundings; to look and act older than her years. Alertonic—*a prescription tonic*—can help your patient become her normal self again. Alertonic helps relieve mild depression, revive interest and restore purposeful activity promptly...with a formula that is efficient *and* economical. Alertonic contains a mild central stimulant (pipradrol hydrochloride), 15% alcohol, essential vitamins and minerals. No hormones or MAO-inhibiting drugs are included. No iron. No iodine. One pleasant-tasting tablespoonful before each meal comprises the usual daily dose.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS-stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive-compulsive states.

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Pleasant tasting Pediatric Piptal with Phenobarbital is miscible in milk, formulas and fruit juices, and may also be administered by dropper directly on the infant's tongue. Dosage is 0.5 cc. 15 minutes before feeding; in severe cases, 1.0 cc. four times daily. High doses may occasionally cause constipation with tenesmus and, rarely, flushing without fever. Contraindicated in bowel obstruction or sensitivity to phenobarbital or anticholinergics. Available in 30 cc. dropper bottles, droppers calibrated to deliver 0.5 cc.

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gastric ulcer

PIPTAL® (pipenzolate bromide) efficiently suppresses acid secretion and motility ...relieves pain and spasm of peptic ulcer. Despite its potent gastrointestinal effects, "its clinically effective therapeutic dose is well below that required to produce side reactions."[1] Because urinary retention is rarely a problem, PIPTAL (pipenzolate bromide) is "a highly desirable drug in the treatment of peptic ulcer in older patients ..."[2] Tolerance to PIPTAL (pipenzolate bromide) has not been demonstrated, and the drug may be administered over prolonged periods without loss of efficacy. *PIPTAL-PHB is specifically designed for the tense ulcer patient who will benefit from the sedative effect of phenobarbital.*

1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. 8:73-77 (Jan.) 1957

2—Asher, L.M.: Am. J. Digestive Diseases 4:272 (Apr.) 1959

PIPTAL®
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PIPTAL®-PHB
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IN BRIEF: PIPTAL—Each tablet contains 5 mg. pipenzolate bromide, PIPTAL-PHB—Each tablet (or 5 cc. of elixir) contains phenobarbital (warning: may be habit forming) 16.0 mg., Piptal (pipenzolate bromide) 5 mg. The elixir contains alcohol 20%.

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S. Richardson Hill, Jr., M. D.
Dean
Medical College of Alabama

October 28, 1965



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Thomas S. Hosty, Ph.D., Director

September 1965

Examinations for intestinal parasites	1,419
Typhoid cultures (Blood, feces, urine and other)	377
Examinations for malaria	3
Examinations for gonococci	2,113
Serologic tests for syphilis (blood and spinal fluid)	34,533
Darkfield examinations	1
Agglutination Tests	6
Examinations for diphtheria bacilli and vincent's	13
Complement fixation tests	226
Examinations for Negri bodies (smears and animal inoculations)	211
Water examinations	2,660
Milk and dairy products examinations	3,620
Examinations for tubercle bacilli	3,795
Miscellaneous examinations	8,881
Total	57,853

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

Current Morbidity Statistics

1965

	August	Sept.	*E. E. Sept.
Tuberculosis	114	111	142
Syphilis	191	192	108
Gonorrhea	326	389	334
Chancroid	1	2	3
Typhoid fever	1	1	1
Undulant fever	1	0	0
Amebic dysentery	2	4	4
Scarlet fever & strep. throat	145	229	61
Diphtheria	1	0	2
Whooping cough	2	0	18
Meningitis	7	6	6
Tularemia	0	0	0
Tetanus	1	0	2
Poliomyelitis	0	0	9
Encephalitis	0	0	1
Smallpox	0	0	0
Measles	20	24	20
Chickenpox	2	2	3
Mumps	10	3	15
Infectious hepatitis	39	39	39
Typhus fever	0	0	2
Malaria	0	0	0
Cancer	1,051	686	613
Pellagra	0	0	0
Rheumatic fever	4	12	12
Rheumatic heart	19	15	24
Influenza	30	31	35
Pneumonia	221	182	121
Rabies—Human cases	0	0	0
Pos. animal heads	3	1	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

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3. FREQUENCY OF ISSUE: Monthly
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5. LOCATION OF THE HEADQUARTERS OR GENERAL BUSINESS OFFICES OF THE PUBLISHERS (Not printers): 19 South Jackson Street, Montgomery, Alabama
6. NAMES AND ADDRESSES OF PUBLISHER, EDITOR, AND MANAGING EDITOR
 - PUBLISHER (Name and address): Medical Association of The State of Alabama, Montgomery, Alabama
 - EDITOR (Name and address): William L. Smith, M. D., 19 South Jackson Street, Montgomery, Alabama 36104
 - MANAGING EDITOR (Name and address): L. P. Patterson, 19 South Jackson Street, Montgomery, Alabama 36104
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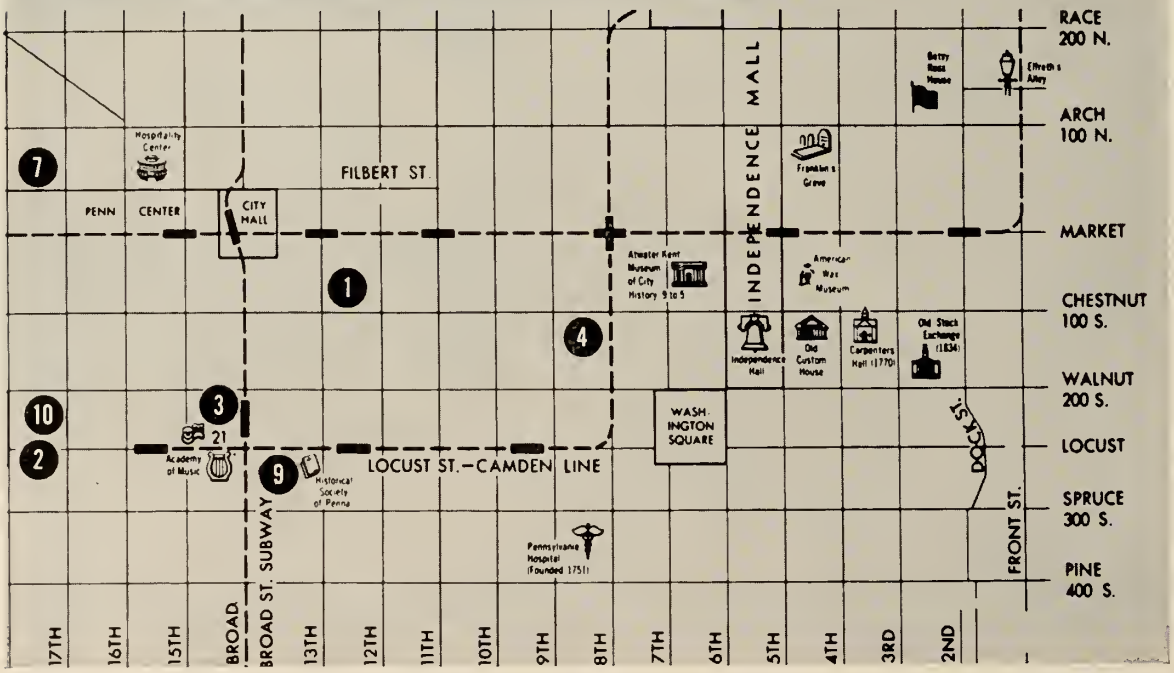
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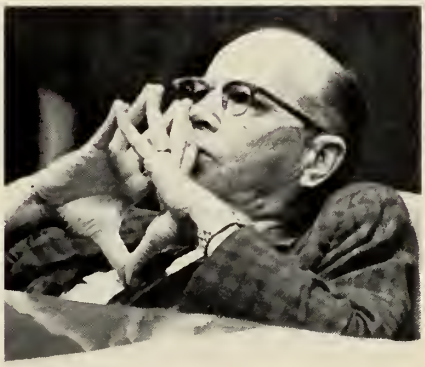
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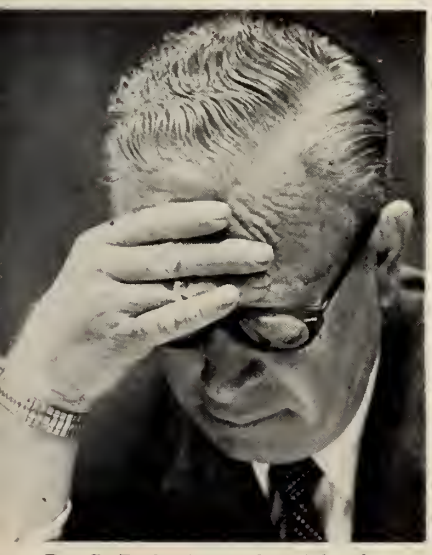
A report on Blue Cross-Blue Shield by Dr. William E. Lawrence of Birmingham captures the attention of President-elect, Dr. J. O. Finney (left), President, James G. Donald (second from right), and Executive Secretary, William V. Wallace (right).



Dr. F. M. Phillippi, Jr., of Brewton (second from right) has attention diverted by cameraman while (from left) Drs. William L. Smith, Association Secretary-Treasurer from Montgomery; A. F. Toole from Talladega; and E. Bryce Robinson, Jr., AMA delegate, Fairfield; carefully heed the business at hand.



Vice-president H. E. Askin of Alexander City gives thoughtful study to the report he is about to make.



Dr. S. Buford Word of Birmingham muses over report at MASA's Trustee Meeting.



"Let's go over that last line again," Dr. S. J. Campbell of Birmingham seems to be saying.



The Trustee from Arab, Dr. Ellis Porch, rivets attention on speaker during Sunday Session.

Candid camera photos made by Dr. William A. Daniel, Jr., Board of Trustees member from Montgomery, Alabama.

The Woman's Auxiliary



Mrs. J. F. Crenshaw
President



Mrs. Howard C. Johnson
Vice-President, Northwest District

It is a pleasure and a privilege to be the Vice-President of the Woman's Auxiliary to the Medical Association of the State of Alabama from the Northwest District.

We are all in the same boat—trying to meet our AMA-ERF quota, promoting Paramedical careers, adjusting our committees to our own needs, driving a "taxi" for our children, and trying to keep the husband happy.

We here in Colbert County were the host county for the Northwest District Meeting, Thursday, September 30. Our main idea was to mix pleasure with business. We worked diligently to crowd into one day many things that would normally take three. Our area has not only many places of breathtaking beauty, but also many sites of historical interest.

It was the first time our area has had a district meeting, and needless to say, we believe it was an enjoyable and informative meeting.

Mrs. James F. Crenshaw, our State President, was among those present, along with other State Officers and Committee Chairmen. Total registration numbered 64.

Camille Johnson

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Alabama Department of Public Health

Syphilis Epidemic In A Southern Prison

W. H. Y. Smith, M. D., M. P. H.

Director, Bureau of Preventable Diseases

An epidemic of syphilis was recently found and corrected at the Atmore State Prison by the Alabama Department of Public Health and prison authorities. The epidemic was discovered as a result of a number of high titre blood tests and cases continuing to occur within the prison.

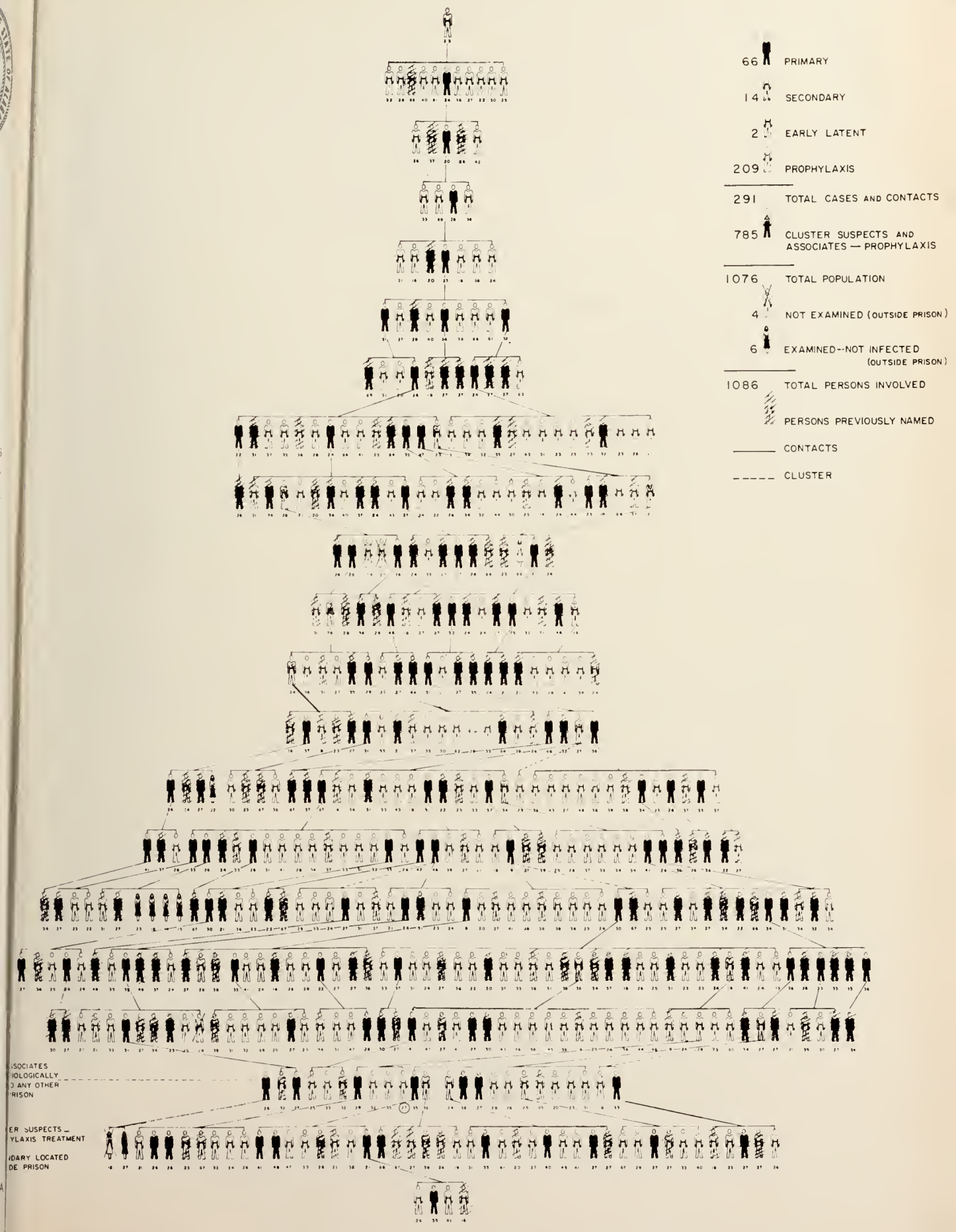
Syphilis had been known to occur regularly in this prison for the last few years. Two years ago prison authorities began to take blood tests on all routine admissions to the prison including prisoners who had been away on short or long term leaves. By positive serology and interviewing, a number of syphilis cases were found from time to time, but most contacts named were located outside of the prison. The infected would only name contacts within the prison who had been previously diagnosed and treated. Therefore it was difficult to find a chain of infection of syphilis from these contacts. Yet new cases were constantly being discovered through the blood testing program.

In February a special team from the Alabama Department of Public Health received permission from prison officials to study the syphilis problem in the prison. This permission was granted after 54 prisoners were reported to have contracted syphilis in the prison during the 1964 calendar year. From March to June 8, 20 more cases of syphilis were reported. Of these 20 cases, one early latent case and five primary cases were found on the eighth of June. This discovery led to an agreement between prison authorities and the State Health Department for the "Blitz" team to move in. ("Blitz" is a term recently chosen to describe a sudden all out attack on an outbreak of venereal disease in Alabama.) According to the agreement, the health department would furnish the diagnostic manpower and the prison would supply medicine for the treatment and prevention.

The following day, June 9, a team of six men began the Blitz, and all prisoners were blood tested in one and one-half days. The health department laboratories in Montgomery and Mobile gave these tests priority over routine laboratory activities so blood test reports were obtained rapidly. Of the total prison population, 291 suspects were examined during the two and one-half day Blitz. Sixty-six primary cases, 14 secondary cases, and two early latent cases were found. During the Blitz all syphilis cases and the remaining 209 known contacts were treated with 2.4 million units of bicillin. In the following day and a half the prison physician

(Continued on Page 394)

SYPHILIS EPIDEMIC IN SOUTHERN PRISON



BUREAU OF VITAL STATISTICS

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA, AUGUST, 1965

Ralph W. Roberts, M. S., Director

Live Births Deaths Causes of Death	Number Registered During August 1965			Rates* (Annual Basis)		
	Total	White	Non-White	1965	1964	1963
Live Births	6,304	4,004	2,300	21.3	24.8	25.2
Deaths	2,484	1,668	816	8.4	8.4	8.2
Fetal Deaths	141	58	83	21.9	23.7	20.1
Infant Deaths—						
under one month	142	85	57	22.5	17.9	21.8
under one year	164	96	68	26.0	25.2	27.0
Maternal Deaths	3	2	1	4.6	4.1	6.8
Causes of Death						
Tuberculosis, 001-019	23	13	10	7.8	8.7	7.3
Syphilis, 020-029	4	3	1	1.4	1.7	1.0
Dysentery, 045-048					0.7	
Diphtheria, 055					0.3	0.7
Whooping cough, 056					0.3	
Meningococcal infections, 057	1	1		0.3	0.3	0.7
Poliomyelitis, 080, 081						
Measles, 085	2	1	1	0.7		
Malignant neoplasms, 140-205	353	265	88	119.4	123.8	106.2
Diabetes mellitus, 260	49	31	18	16.6	11.4	11.2
Pellagra, 281						
Vascular lesions of central nervous system, 330-334	327	189	138	110.6	120.0	117.7
Rheumatic fever, 400-402						0.7
Diseases of the heart, 410-443	778	568	210	263.2	260.4	269.9
Hypertension with heart disease, 440-443	96	39	57	32.5	36.8	35.6
Diseases of the arteries, 450-456	59	45	14	20.0	20.5	16.8
Influenza, 480-483					0.3	0.3
Pneumonia, all forms, 490-493	56	32	24	18.9	16.3	19.2
Bronchitis, 500-502	4	4		1.4	2.4	
Appendicitis, 550-553	1		1	0.3	1.7	2.4
Intestinal obstruction and hernia, 560, 561, 570	13	11	2	4.4	4.5	5.6
Gastro-enteritis and colitis, under 2, 571.0, 764	1		1	0.3	3.8	6.3
Cirrhosis of liver, 581	18	10	8	6.1	6.6	6.3
Diseases of pregnancy and childbirth, 640-689	3	2	1	4.6	4.1	6.8
Congenital malformations, 750-759	34	27	7	5.4	4.6	3.7
Immaturity at birth, 774-776	42	21	21	6.7	5.2	6.7
Accidents, total, 800-962	217	160	57	72.4	62.8	62.2
Motor vehicle accidents, 810-835, 960	116	94	22	39.2	31.9	32.1
All other defined causes	317	155	162	107.2	120.0	118.7
Ill-defined and unknown causes, 780-793, 795	182	130	52	61.6	50.3	36.0

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

SYPHILIS EPIDEMIC

(Continued from Page 392)

and staff administered prophylaxis to the other 785 cluster suspects (group testing) and associates within the prison. Each of these was given 2.4 million units of bicillin.

Interviewing was proved to be an especially effective procedure in detecting syphilis and tracing this epidemic. By interviewing the six original cases found on June 8, venereal disease investigators found a total of 82 cases of syphilis. This is a large figure amounting to more than 7.5 per cent of the prison population.

By agreement with the prison officials each subsequent new admission is blood tested, and each one is given 2.4 million units of bicillin whether he is infected or not. If it is impossible to treat the prisoner at the moment of entry, he is placed in isolation until treatment can be given.

As a result of this action in the Atmore prison, not a single case of syphilis or gonorrhea had been reported at the time of this report 18 weeks later. This demonstrates the complete control of syphilis in a captive population by universal treatment of all infected persons and prophylactic treatment of all associates with penicillin.

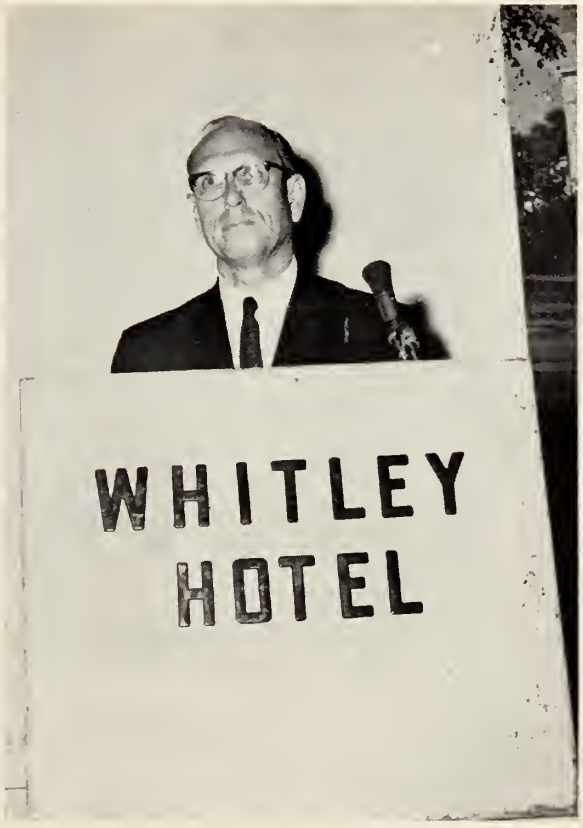


"I didn't have the heart to tell that nice young intern that this is the wrong leg."

Reprinted from: "The New Physician"



Shown above are the speakers at the October meeting of the Medical Society of Montgomery County. Left to right are Dr. Robert Adams, Montgomery, who gave a tribute to Dr. Champ Lyons before introducing speakers from the Medical College of Alabama, Dr. Merrill Bradley, Dr. Alan Dimick, and Dr. Bruce Sullivan.



Pictured is Dr. H. J. Till, President of the Medical Society of Montgomery County. Dr. Till presided at the October meeting.

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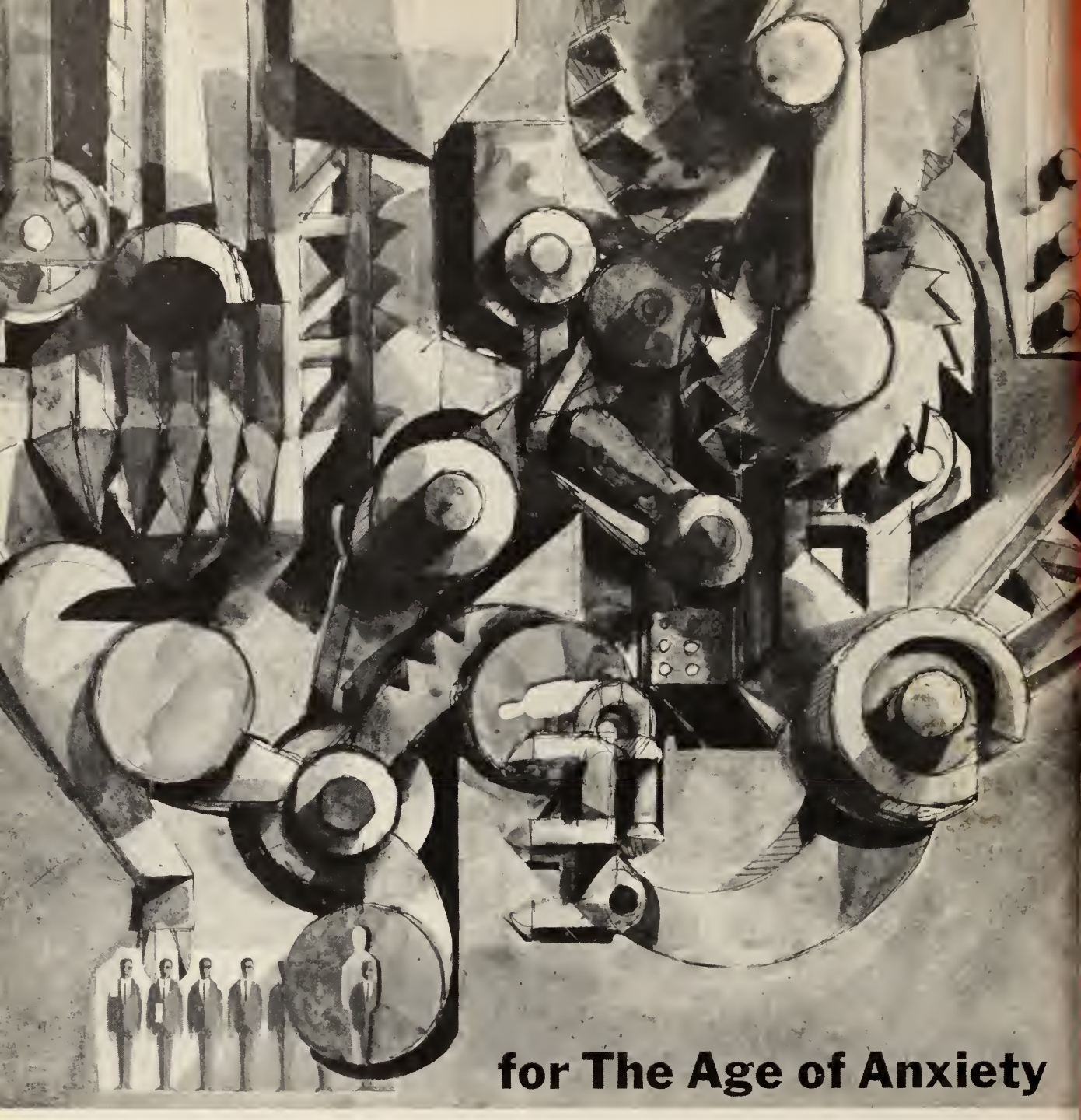
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DECEMBER 1965



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(1) Portnoy, J.; Brewer, J. and Harris, A.: PUBLIC HEALTH REPORTS, *77:*645-652, August 1962. (2) Joseph, J. M. and Warner, G. S.: A WORKSHOP MANUAL, Md. State Dept. Health, Bureau of Lab., Balto., Md., September 1962. (3) Wollenweber, H. L.: OFF. PATH., *2*, February 5, 1963. (4) Portnoy, J.: MILIT. MED., *128:*414-417, May 1963. (5) Portnoy J.: THE AMER. JOUR. OF CLIN. PATH., *40:*473-479, November 1963. (6) Buck, A. A. and Mayer, H.: THE AMER. JOUR. OF HYG., *80:*85-90, July 1964. (7) Brown, W. J.; Donohue, J. F. and Price, E. V.: PUBLIC HEALTH REPORTS, *79:*496-500, June 1964. (8) Clayton, J. L.; Lindhardt, E. M. and Fraser, R. S.: PUBLIC HEALTH LAI *22:*206-207, November 1964. (9) Lucatorto, F. M.; Katz, B. D. and Toto, P. D.: THE J.A.D.A., *69:*697-699, December 1964. (10) Portnoy, J.: PUBLIC HEALTH LAB., *23:*43, March 1965. (11) Reed, E. L.: PUBLIC HEALTH LAB., *23:*96-103, May 1965.

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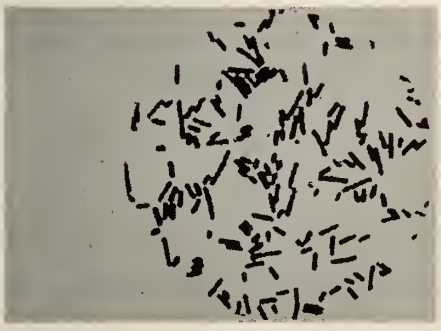
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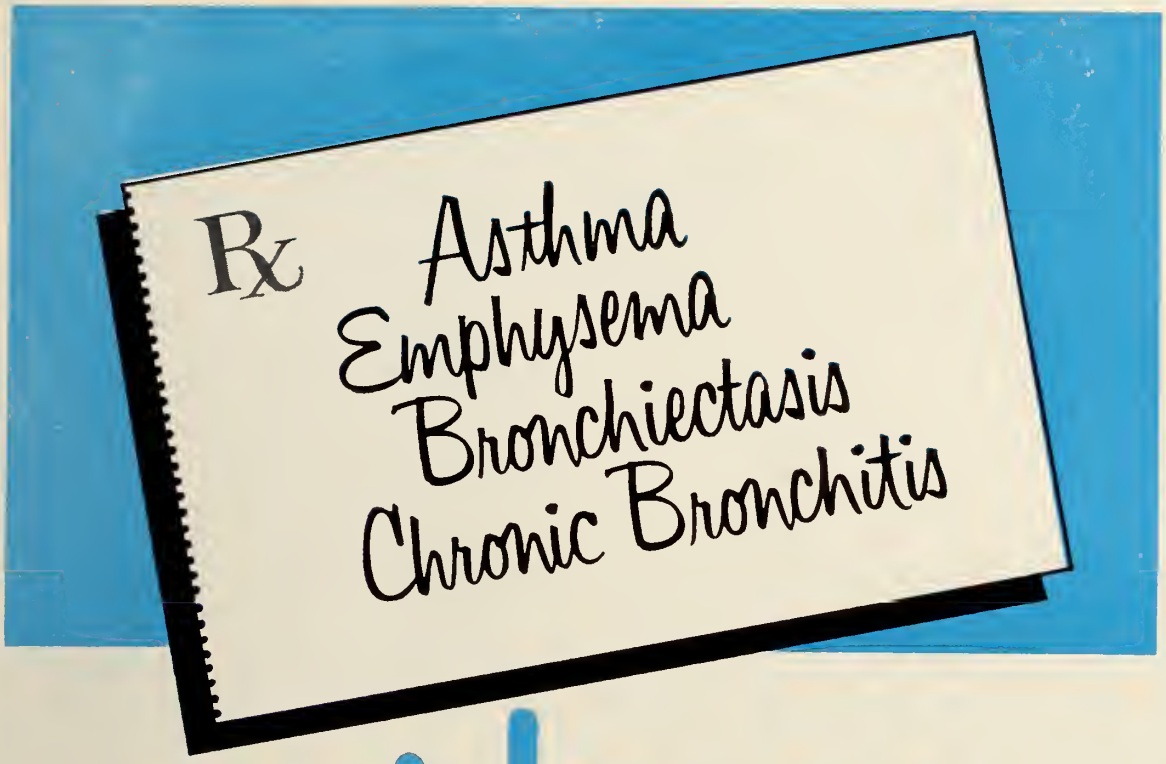
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President's Page



Now that organized medicine has lost the first round in its battle against socialized medicine, it is imperative that members of the medical profession retrench themselves and take a good hard objective look at the future.

As Dr. Edward R. Annis so ably stated in his address before the National Orientation Conference on Public Law 89-97, on October 1, 1965, the loss of this battle does not mean that medicine was wrong to oppose this bad legislation, or that the fight to win the war against socialized medicine should not continue with increased vigor. The battle in opposition to Public Law 89-97 was lost because a majority of the members of the Senate and the House of Representatives of the United States hold liberal and socialistic views. This type of progress toward a socialistic state will be stepped up in the future unless the personalities in Congress can be changed so that a majority will be devoted to the preservation of our traditional American freedoms and the free enterprise system in this country. Large amounts of money are being expended by organized labor and other groups to see that future Congresses contain an even greater majority of liberal senators and representatives. Members of the medical profession must combine with members of free industry, other free professions, private insurance companies and others to financially support the candidacy of those individuals who subscribe to a similar political philosophy to our own. They must be individuals who, on the basis of previous performance or declared intention, will work and vote for the preservation of free enterprise in this country.

An organization known as the Alabama Medical Political Action Committee (ALAPAC) which is affiliated with the American Medical Political Action Committee (AMPAC) was organized in Alabama in 1962 and solicits members from among the members of the medical profession, their wives, other members of their families, friends and others. ALAPAC is not a committee of the Medical Association of the State of Alabama, or of the American Medical Association, and functions independently of it although its Chairman and Board of Directors are appointed by the President of MASA. All members of MASA are requested to become members of ALAPAC and are asked to voluntarily contribute funds to be used for candidate support and for education and information of its members concerning pre-

(Continued on Page 405)

(Continued from Page 402)

vious voting records of candidates, etc. The classes of membership in ALAPAC are as follows:

A. Associate Membership—$35.00 per year ($10.00 of which shall be transmitted to AMPAC as dues in that organization)

B. Active Membership—$75.00 per year ($20.00 of which shall go to AMPAC)

C. Sustaining Membership—$198.00 ($99.00 of which shall go to AMPAC)

D. Student intern and Resident Membership —$15.00 ($5.00 of which shall go to AMPAC)

The AMPAC funds which are contributed as dues from the various state political action committees will be used in support of candidates to the Congress of the United States from the different sections of the country. This political action on the part of doctors and their friends and associates has not yet begun to function with nearly the strength of which it is capable. If this program is strongly supported by the doctors of the State of Alabama, by members of their families and their friends; and if, in turn, there is similar strong support in other states of the United States so that the American Medical Political Action Committee can exert a strong influence upon future elections to the Congress of the United States; and if these activities are coordinated with INPAC, the political arm of industry, BIPAC and other groups devoted to preservation of the free enterprise system, the tide of socialistic legislation can be reversed in future Congresses and our freedoms can be preserved. Your support of ALAPAC is strongly recommended.

James G. Donald, M. D.

James G. Donald, M. D.,
President

Personals

A prominent Cullman physician, Dr. Frank Stitt, Sr. has been elected to the Howard College Board of Trustees to succeed the late Hugh Bindley, also of Cullman. A native of Wedowee, Dr. Stitt has practiced medicine in Cullman for 25 years. He is a graduate of the University of Alabama and the Medical College of Alabama and a member of the International College of Surgeons. His son, Dr. Frank Stitt, Jr. is also a surgeon at Cullman.

* * *

Dr. W. D. Anderson, Tuscaloosa radiologist, is the new President of the Alabama Division of the American Cancer Society. Since 1945 the society has allocated $1,593,737 to Alabama institutions for cancer research. Dr. Anderson is a graduate of the University of Alabama and received his medical degree from George Washington University.

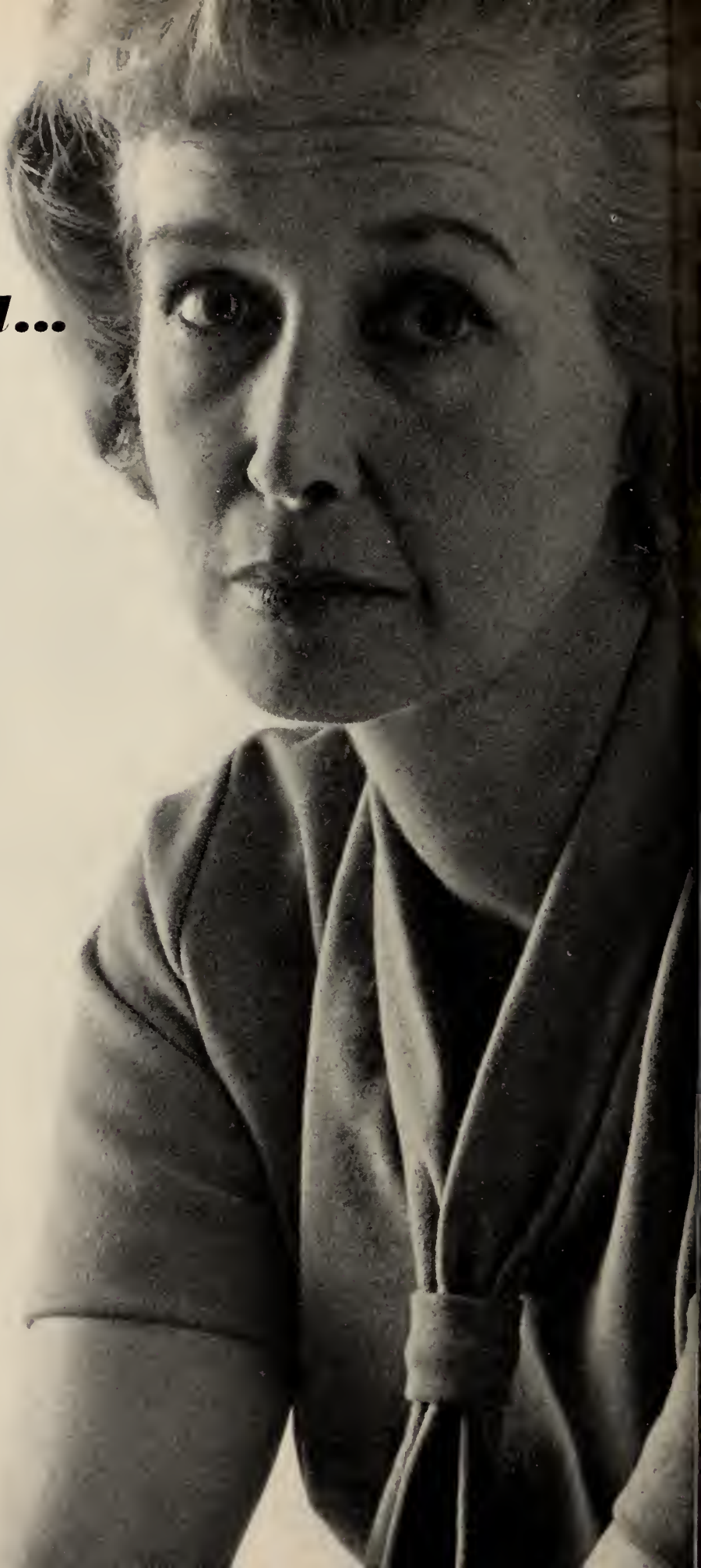
* * *

Featured speaker at a joint meeting of Oneonta Jaycees and Civitans recently was Dr. William J. Tally, Medical Director of District IV Tuberculosis Hospital in Gadsden. Members of the Blount County Medical Society were invited to attend the meeting. Dr. Tally received his B. S. and M. D. degrees from Tulane University. He was in private practice at Gadsden until accepting the post of the director of the tuberculosis hospital. He currently is serving as President of the Alabama Thoracic Society.

* * *

The Florence Herald recently published a "Personality Sketch" on Dr. William Smith Bradley, Jr., a neurologist of that city. A graduate of Tulane University Medical School, Dr. Bradley has resided in Florence since 1958 when he joined the medical staff at Florence Clinic.

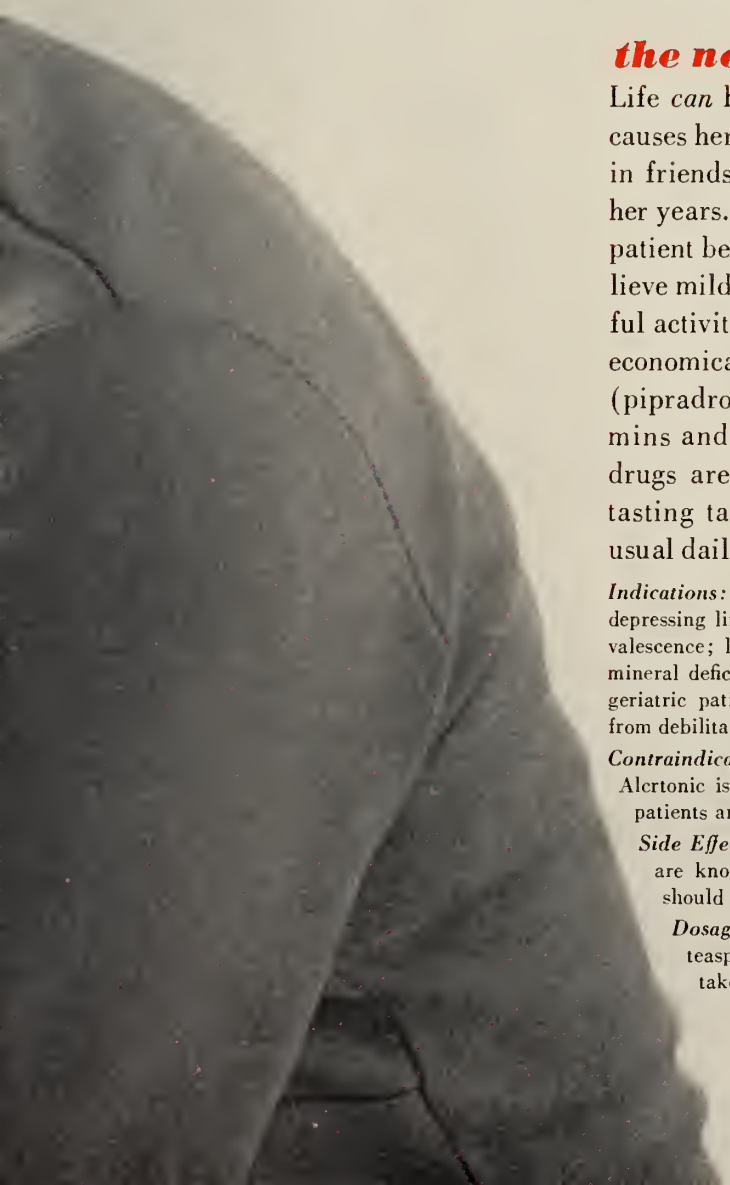
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to be so tired...



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Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline†, 100 mg.; inositol†, 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

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Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

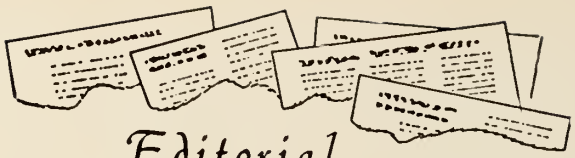
Contraindications: As with other drugs with CNS-stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive-compulsive states.

Side Effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

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Editorial COMMENT

Peace On Earth, Good Will To Men

This is the season of the year when Christians pause to pay humble tribute to One who was born upon this earth 2,000 years ago.

Even though His was a mission of Peace to all mankind, once again this nation finds itself locked in lethal warfare for a people and a country far removed from our hearthstones.

But is it so strange that we would do battle in a strange and faraway land? Isn't this in strictest obedience to our Savior's commandment to "Love thy neighbor"? Did not God shower his blessings upon David as he went forth to slay Goliath?

We who inhabit this blessed land known as America, surrounded by our families and loved ones, our hearts untroubled by the constant dangers attendant upon warfare, have even more cause in this year 1965 to cast our eyes Heavenward in gratitude and humility.

It is in this spirit that we, the Officers and Trustees of the Medical Association of the State of Alabama and personnel of the Central Office wish to each of you a full measure of peace, good will, and happiness. May you enjoy a

MERRY CHRISTMAS AND A HAPPY NEW YEAR.



Highlights Of 1965 Midyear Conference

The Midyear Conference of officers and committeemen was called by President James G. Donald to meet November 18, 1965, at the Midtown Holiday Inn, Montgomery.

Reports from all active committees covering the period from the close of the annual session last April until the present were submitted to the Board of Trustees, which met the night preceding the Midyear Conference.

Meeting simultaneously was the Board of Directors of ALAPAC.

Approximately 100 physicians and their guests attended the luncheon meeting at which Dr. Edward R. Annis of Miami, Florida, Past President of the American Medical Association, was the featured speaker. Dr. Annis graphically detailed the threat of socialism to the practice of medicine and called upon physicians to prepare themselves for future attacks from the liberal left wing.

Another featured speaker of the one-day conference was Dr. Hoyt Gardner of Louisville, Kentucky, a member of the Board of Directors of AMPAC, who addressed the morning session on the subject: "The State Pac Movement in a Two-Party State." Dr. Gardner attended the meeting of the ALAPAC Board of Directors on the preceding night and on both occasions strongly urged Alabama physicians to become active in politics.

Highlights from the reports of committees follow:

Public Relations and Economics

The report of the Committee on Public Relations and Economics was delivered by Dr. Carl Grote, Jr. of Huntsville, Chairman. He stated that the committee met in July and outlined the year's work. "Since that meeting sub-committees have been most active," Dr. Grote continued.

The Subcommittee on Awards and Interprofessional Relations has received nominations for the William Crawford Gorgas Award and the Medical Reporter Award. No nominations were received for the newly created William Sanders Award.

The subcommittee has established a certificate of merit which may be presented by

County Medical Societies to any individual who has performed an outstanding service in the field of health. The subcommittee on Mass Media and Personal Public Relations has two programs under consideration, the first is a series on Quackery scheduled for Educational TV Network showing which will originate from Auburn University. It appears that this may well turn into a 26-week series rather than the 13-week series originally discussed. The second program is a proposed conference on medicine and pharmacy tentatively scheduled for Feruary 19 and 20 in Birmingham. Out-of-state speakers will be invited to participate in the program.

Other action of the Committee on Public Relations and Economics include the solicitation of funds for AMA-ERF. This will begin within the next few days.

Legislation

The Chairman of the Committee on Legislation, Dr. E. L. McCafferty, Jr. of Mobile, reported that this group had met three times since last April for the purpose of studying and determining the value of legislation proposed in three extraordinary sessions and one regular session held during 1965.

The Chairman stated that approximately 100 bills were introduced at these four sessions and observed that fewer than a dozen had been actively sponsored by the Medical Association of the State of Alabama or the State Department of Public Health. He called for creation of machinery whereby physicians can be consulted on all legislation affecting the public health before it is passed.

"It was significant," the Chairman continued, "that every bill actively supported by the Association was enacted into law and every bill opposed by it was defeated."

Dr. McCafferty listed as the more important health measures enacted during the past year (1) One cent cigarette tax for the Health Department; (2) Removal of salary ceilings in the Health Department; (3) Ten million dollar bond issue for the Medical College; (4) A new Medical Scholarship bill; and (5) Creation of a Department of Mental Health.

Allied Medical Services

The Chairman, Dr. W. J. Atkinson, Jr. of Mobile, stated that this committee's recommendation to the Association relative to a program in the schools from the fifth to twelfth grades to educate children about the dangers of smoking was approved. He presented to the committee a copy of a booklet entitled, "Smoking and Its Relationship to

(Continued on Page 412)



Attentive listeners at the Midyear Conference during speech by Dr. Edward R. Annis, past President of AMA, were (standing) Dr. E. L. McCafferty, Chairman, Committee on Legislation, and (seated, from left) Drs. H. H. Hutchinson, Ross McBryde and R. M. Miller, Sr.



for the comprehensive control of the pain cycle

TRANCO-GESIC®

CHLORMEZANONE with ASPIRIN

100 mg. 300 mg.

Because pain is frequently aggravated and perpetuated by both anxiety and muscular tension, the combination of aspirin with a well tolerated tranquilizer–muscle relaxant (Trancopal® (brand of chlormezanone)) is exceptionally effective.

TRANCOPAL is a "Tranquilaxant" which calms anxiety and tension, relieves muscle spasm, and enhances the analgesic effect of aspirin by subduing *emotional responses* to pain.

NON-NARCOTIC ANALGESIC, with tranquilizing and muscle relaxant properties

In low back pain

sciatica, lumbago; musculoskeletal pain associated with strains and sprains

In tension headache

premenstrual tension and dysmenorrhea

Side effects such as gastric distress, occasional weakness, sedation or dizziness may be noted. Ordinarily, these may be reversed by a reduction in dosage or temporary withdrawal of the drug. TRANCO-GESIC should not be administered to persons known or suspected to have an idiosyncrasy to acetylsalicylic acid.

Dosage for adults is usually 2 tablets three or four times daily, the suggested dosage for children from 5 to 12 years is 1 tablet three or four times daily.

Supplied in bottles of 100 and 1000 tablets.

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New York, N. Y. 10016



Dr. James G. Donald, President of MASA, is shown (right) with Dr. W. J. Atkinson, Jr., Chairman of the Committee on Allied Medical Services as latter was being introduced to make his report.

(Continued from Page 410)

Health and Disease" as prepared by the Michigan Health Council, which has been a valuable guide for patterning a program in Alabama.

The Chairman stated that he had been in contact with the Mobile County Board of Education and that contact has been made by Dr. Ira Myers with the State Superintendent of Education, Mr. Austin R. Meadows.

Dr. Oliver reported that four meetings with representatives of the Alabama Tuberculosis Association, Alabama Division, American Cancer Society, and Alabama Heart Association and Dr. Myers and the staff of the State Department of Public Health have resulted in the preparation by the State Department of Public Health of a kit designed for use in the schools; one for utilization by the teacher, and one for the student. Dr. Oliver further stated that 10,000 copies of the kits are expected to be available in December for distribution by the State Department of Education to be introduced into the curriculum during the last half of the current school year in Alabama.

It was the consensus that the multiple approach to education on smoking as being instituted by the State Department of Education is very effective and should be encouraged by the Medical Association of the State of Alabama.

It was also the consensus that the possibility of the facilities of Educational Television be investigated to determine what programming might be arranged on the subject of the dangers of smoking. Also recommended was local speakers bureaus.

Insurance

The Chairman, Dr. C. A. Lightcap of Mobile, reported that the committee had met twice since the Annual Session—the first

(Continued on Page 417)

Announcing
EUTRON™

pargyline hydrochloride 25 mg. and methyclothiazide 5 mg.

for control of moderate to severe hypertension

Unique combination produces greater antihypertensive effect with lower doses

Eutron is the combination in a single tablet of 25 mg. Eutonyl (pargyline hydrochloride) and 5 mg. Enduron (methyclothiazide). This combination produces greater therapeutic effect than that of either component used alone. Side effects may be milder, too, as dosages are generally lower. The effective dosage is usually one tablet, once daily. Tablets are scored for greater dosage flexibility.



Each Eutron tablet contains two proven antihypertensives in the ratio shown to be most effective in most patients.

TM—TRADEMARK

New **EUTRON** extends your range of treatment in moderate to severe hypertension



A single product you can use even in the presence of congestive heart failure or edema

Eight out of 10 patients respond

In clinical trials, Eutron produced normotension or a significant reduction in blood pressure in eight out of 10 patients studied. The rationale for the product is this: Eutonyl used alone is a potent antihypertensive. Its antihypertensive action is markedly enhanced by Enduron, a potassium-sparing thiazide.[1,2,3] The combination (Eutron) thus produces greater antihypertensive effect with lower dosages of the Eutonyl component, and milder side effects may be seen.

512214

1. Torosdag, S., Schvartz, N., Fletcher, L., Fertig, H., Schwartz, M. S., Quan, R. F. B., and Bryant, J. M., Pargyline Hydrochloride as an Antihypertensive Agent With and Without A Thiazide, Am. J. Cardiol., 12:822, Dec., 1963.

2. Pollack, P. J., Pargyline Hydrochloride and Methyclothiazide Combined In The Treatment of Hypertension, Cur. Thera. Res., 7:10, Jan., 1965.

3. Bryant, J. M. et al., Antihypertensive Properties of Pargyline Hydrochloride, New Non-Hydrazine Monoamine Oxidase Inhibitor Compared with Sulphonamide Diuretics, J.A.M.A., 178; 406, Oct., 1961.



BP reductions in the recumbent and sitting positions often are nearly as great as in the standing. In clinical trials, the average *recumbent* BP reduction was 36/18 mm. Hg.



The average *standing* reduction in clinical trials was 45/22 mm. Hg. Thus the difference between the standing and recumbent readings was only 9/4 mm. Hg.

Significantly lowers blood pressure in all body positions; less likelihood of orthostatic hypotension

In clinical trials, the average reduction in standing blood pressure was 45/22 mm. Hg.; in the sitting position it was 48/20 mm. Hg.; and in the recumbent position, 36/18 mm. Hg.

Because Eutron effectively reduces blood pressure in all body positions, there is reduced likelihood of orthostatic symptoms or hypotension.

This was reflected in the relatively mild character of side effects seen in clinical trials (see below).

Smooth and gradual onset

Onset of antihypertensive action is usually quite smooth. Initial reduction of systolic and diastolic readings is usually seen within a week – maximum reduction in seven to ten days.



Less troublesome side effects may be seen; frequent improvement in "sense of well-being"

Fewer than 1% of patients studied discontinued Eutron therapy because of side effects. This is due in part to the relatively low dosage needed with the combination. Usual recommended dose is one tablet daily–that is, 25 mg. Eutonyl with 5 mg. Enduron. *This is about half the usual therapeutic dose of Eutonyl given alone.* As a consequence side effects may be milder. And, as with Eutonyl given alone, the patient may well note an increased sense of well being. This is in distinct contrast to most other antihypertensive therapy.

ABBOTT

Prescribing information for **EUTRON**

INDICATIONS: Eutron (pargyline hydrochloride and methyclothiazide) is indicated in the treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. It is not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

CONTRAINDICATIONS: Eutron is contraindicated in patients with pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained it cannot be recommended for use in patients with malignant hypertension, children (under 12 years of age), or pregnant patients.

The concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. A drug-free interval of two weeks should separate therapy and use of these agents.

WARNINGS: Pargyline hydrochloride is a monoamine oxidase inhibitor. Patients should be warned against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When it is necessary to administer alcohol, narcotics (notably meperidine), antihistamines, anesthetics, barbiturates and other hypnotics, sedatives, tranquilizers, or caffeine, these agents can be used cautiously at a dosage of ¼ to ⅕ the usual amount. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Patients should be warned about the possibility of postural orthostatic hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Potassium depletion is unlikely at the recommended dosage, but if it occurs, adjust dosage or withdraw or provide added natural food sources of potassium; potassium tablets should be avoided wherever possible, as bleeding or obstructive ulceration of the small bowel has been associated with their use; potassium levels should be especially watched if the patient is on digitalis or steroids, or if hepatic coma is impending.

PRECAUTIONS: When determining the antihypertensive effect of Eutron, blood pressure should be measured while the patient is *standing*. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Pargyline has not been shown to cause damage to body organs or systems. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. The drug should be used with caution in patients with liver dysfunction. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

Elevated blood urea nitrogen, serum uric acid or blood sugar are possibilities attributable to the methyclothiazide in Eutron. Methyclothiazide may also reduce arterial response to pressor amines. Blood dyscrasias, including thrombocytopemia with purpura, agranulocytosis and aplastic anemia, have been seen with thiazide drugs.

SIDE EFFECTS: The use of pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve. Nocturia has been observed with the combination. If side effects persist, despite symptomatic therapy or reduction of the dose, discontinue the drug.

ABBOTT

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meeting held April 22 in Birmingham and the second held October 10, also in Birmingham. Among matters discussed was the lengthy and complicated insurance forms which physicians are required to execute. It can now be reported that these forms have now been standardized and are available to all desiring them.

AMA Delegation

Dr. M. Vaun Adams of Mobile, one of Alabama's three delegates to AMA, reported on actions taken by that body during the past year. He noted that the House of Delegates had convened in two call sessions due to the problems posed by the Medicare issue.

Board of Censors

Report on the Board of Censors and State Committee on Public Health was made by Dr. John M. Chenault of Decatur. After briefly reviewing the role played by the Board of Censors as it relates to the Medical Association, the Board of Medical Examiners, and the State Board of Health, Dr. Chenault reviewed activities of the past eight months.

Text of this report occurs on page 458.

Maternal and Child Health

The Chairman, Dr. G. L. Wideman of Birmingham, reported that the committee continues to send questionnaires to physicians relative to maternal deaths. Copies of the responses are sent by certified mail to the members of the committee prior to meeting. At the time of the recent meeting 15 responses had been received, and according to statistics received through July, only 17 maternal deaths had occurred this year. This is 88 per cent reporting. It was noted that the leading cause of death continues to be hemorrhage. A complete analysis of the maternal deaths will be submitted with the annual report.

It was the consensus of the members that a page of the *Journal* of the Medical Association of the State of Alabama be devoted to

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As the Midyear Conference drew to a close, attendance waned and there were many empty chairs in the room. Among those who stayed until the end were (left to right) Dr. G. C. Murchison, Jr., Dr. E. B. Glenn, immediate past president, Dr. William L. Smith, MASA Secretary-Treasurer, and Dr. W. A. Daniel, a MASA Trustee.

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It wasn't all work. Mrs. Jack Pilkington of Selma and Dr. John Martin of Montgomery paused during committee reports to exchange pleasantries. Many wives attended the conference with their husbands.



Dr. C. A. Lightcap, Chairman of the Committee on Insurance makes his midyear report on a subject which is growing in importance to MASA members with enactment of the controversial Medicare Law.

(Continued on Page 421)

DEPROL®

meprobamate 400 mg. +
benactyzine hydrochloride 1 mg.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.
Before prescribing, consult package circular.

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FOR THE



COMPLEX

TRY DEPROL®

meprobamate 400 mg. +
benactyzine hydrochloride 1 mg.

a logical first choice

FOR DEPRESSION

even when complicated by anxiety, tension, insomnia, agitation or rumination.

- **Acts rapidly.**
- **Side effects at recommended dosage infrequent, usually easily controlled.**



The Pain Is Gone

Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

'Empirin'® Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

Keeps the Promise of Pain Relief

BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.

(Continued from Page 418)

case reports on maternal and infant deaths based on data as submitted for review with absolute anonymity being maintained. The first of these articles on maternal and child health, written by Dr. George Cassady, appeared in the November, 1965, issue of the *Journal.*

Dr. George Cassady discussed the possibilities of pursuing the problems relative to perinatal mortality and cited statistics which show that 4,500-5,000 perinatal deaths occurred in the State of Alabama last year. He suggested four possible phases in analyzing infant deaths: (1) the questionnaire method comparable to the maternal mortality study with concentration on isolating specific problems within certain periods before, during, or after birth; (2) local survey approach; (3) recommend the forming of a perinatal study committee in each approved hospital in the State; and (4) speakers bureau.

Rural Health

Dr. Paul Nickerson is Chairman of this committee, which holds quarterly meetings

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Public relations was the subject of the report made to the Midyear Conference of County officers and committeemen by Dr. C. A. Grote, Jr., Chairman of the Committee on Public Relations. Bearing responsibility for MASA's image, Dr. Grote and his group comprise one of the major committees.



Dr. William Waller of Montgomery appears to be hanging on every word of Dr. Annis as the latter called on the conferees to stand fast against the threat of socialized medicine during the featured luncheon session.



Written reports aided those in attendance and Dr. Willard W. Irwin of Moulton followed the proceedings with his copy.

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in conjunction with the Rural Health Council of Alabama.

Among programs sponsored are driver training education and a weekly series of rural health articles sent to newspapers throughout Alabama.

The committee has concerned itself with the evaluation of the need for additional medical and dental personnel and facilities in the State, immunization information program, safety in use of pesticides and other poisons, recruitment of medical personnel for rural areas, and other health programs of interest to the rural population.

The possibility and value in promoting a State Rural Health Conference has been explored by the Council as a means of stimulating interest in health problems at the grass roots level. The need for development of county-area-district rural health councils is thought to be a necessary adjunct to the functioning of an effective rural health program through improving the methods of communication.

It is proposed that a one-day State Rural Health Conference be presented in Montgomery in 1966. Assistance in setting up this Conference has been assured by Dr. Bond Bible, Secretary of the American Medical Association's Council on Rural Health.

Medical Education and Hospitals

This committee presented the paramedical education conference April 24, 1965, in Birmingham. The Conference was designed to air to all interested groups the needs in the health field, the rather complex but available sources of monies for training in these areas at present, and the potential instruction in nursing and technology in proposed junior colleges and in the other colleges already existent. The Conference was sponsored by the University of Alabama Medical Center in co-operation with the Medical Association of the State of Alabama, the Alabama Dental Association, Alabama Hospital Association, Alabama League for Nursing, Alabama Public Health Association, Alabama State Nurses Association, Health Careers Council of Alabama, and the Extension Division, University of Alabama.



Pleasantries during luncheon were exchanged by Dr. James G. Donald, President of MASA, and the guest of honor, Dr. Edward R. Annis, past president of the American Medical Association.

Aging and the Indigent

Following passage of Public Law 89-97 (Medicare) by the National Congress, the Committee on Aging and the Indigent turned its attention to the problem of implementing Alabama laws applicable to Kerr-Mills legislation to make them conform to the new law.

The Chairman, J. Garber Galbraith, M. D., pointed out that Section XIX of Public Law 89-97 largely absorbs the former Kerr-Mills program by using funds previously appropriated to it for medical assistance to families with dependent children and on behalf of the aged, blind or permanently and totally disabled individuals whose income and resources are insufficient to meet the cost of necessary medical care. Section XIX also provides for rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.

Such far-reaching legislation, the Committee decided, makes imperative a thorough legal analysis of Alabama laws pertaining to Kerr-Mills legislation to make certain that they will meet all future requirements of Public Law 89-97. The Committee took cognizance of the fact that such a study may already be underway by the Alabama Department of Pensions and Security but that a special study of the statutes as they apply

(Continued on Page 425)

or mild arthritic problems

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but full steroid is too much

re's a time for *aspirin*—when the pain stiffness are almost bearable and easily trolled....There's a time for full-dosage *roid*—for limited periods, as in severe ritic flare-up....And there's often a time a moderate formulation of the *two*—when ddle-range symptoms, in your judgment, for middle-range therapy. With SIGMAGEN, r arthritic patients get both anti-inflam-tory and analgesic action to relieve ammation, swelling, pain and stiffness.

middle-range therapy with Sigmagen® TABLETS

brand of corticoid-analgesic compound

Each tablet contains 0.75 mg. prednisone, 325 mg. acetylsalicylic acid, 20 mg. ascorbic acid, 75 mg. aluminum hydroxide.

Clinical considerations: Precautions—SIGMAGEN Tablets should be used with the same precautions as other corticosteroids. They should not be used in patients with tuberculosis, peptic ulcer, agitated psychotic states, or herpes simplex of the eye. The physician must be watchful in patients with cardiac decompensation, severe hypertension, diabetes mellitus renal insufficiency, osteoporosis, and marked emotional instability or psychotic tendency. Acute infections must be controlled with appropriate agents. Corticosteroids may mask signs of infection. For more complete details, consult Schering literature available from your Schering Representative or Medical Services Department, Union, N.J. 07083. S-77:



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STRESSCAPS B and C vitamins in therapeutic amounts...help the body mobilize defenses during convalescence...aid response to primary therapy. The patient with a severe infection, and many others undergoing physiologic stress, may benefit from STRESSCAPS.

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Each capsule contains:	
Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 (one month's supply) and 100 (three months' supply).

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY Pearl River, N.Y. Lederle



The most faithful listener at the Midyear Conference and possibly the only one retaining every word that was spoken was this electronic mechanism which usually turns up in the limelight of MASA meetings. It's the tape recorder of Dr. M. Vaun Adams, member of the Board of Censors.

(Continued from Page 422)

to practicing physicians should also be made.

Advisability of shifting total responsibility for Public Law 89-97 to the State Department of Health was considered, but it was the consensus of the members that such action should not be taken because (1) the Department of Pensions and Security has functioned in a manner satisfactory to Medicine in its handling of the Kerr-Mills program, and (2) to shift the program to the Department of Health would entail costly and wasteful duplication of administrative operations.

Each member of the Committee on Aging and the Indigent has received a copy of an analysis of Public Law 89-97 made by the Legislative Department of the American Medical Association for his study and recommendations.

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The Midyear Conference inspired an entire range of emotions, as shown in the photograph above. Interested participants were (nearest camera, from left) Dr. Buford Word and Dr. Ellis Porch, Trustees; Dr. J. Garber Galbraith, Chairman of the Committee on Aging and the Indigent; Dr. Paul Burleson, member of the Board of Censors, and Dr. Harmon Stokes, District Vice President.



Another out-of-state guest invited to address the conference was Dr. Hoyt Gardner of Louisville, Ky., member of the AMPAC Board of Directors, who urged MASA members to become active in political-legislative affairs.

(Continued from Page 425)

The Committee strongly recommends that an attorney be retained by the Medical Association of the State of Alabama to advise members of this organization concerning the many new laws—both state and national—which have been recently enacted as well as those proposed laws presently being drafted.

Membership

Dr. William L. Smith, Secretary of the Medical Association of the State of Alabama, reported that at the time of the publication of the 1965 Roster of the Medical Association, there were 2,298 members on the roll.

Since the Roster was printed and mailed on July 15, 1965, 49 members have been added, 20 members have deceased or removed, and 113 changes of address have been received and recorded.

The present membership total is 2,327.

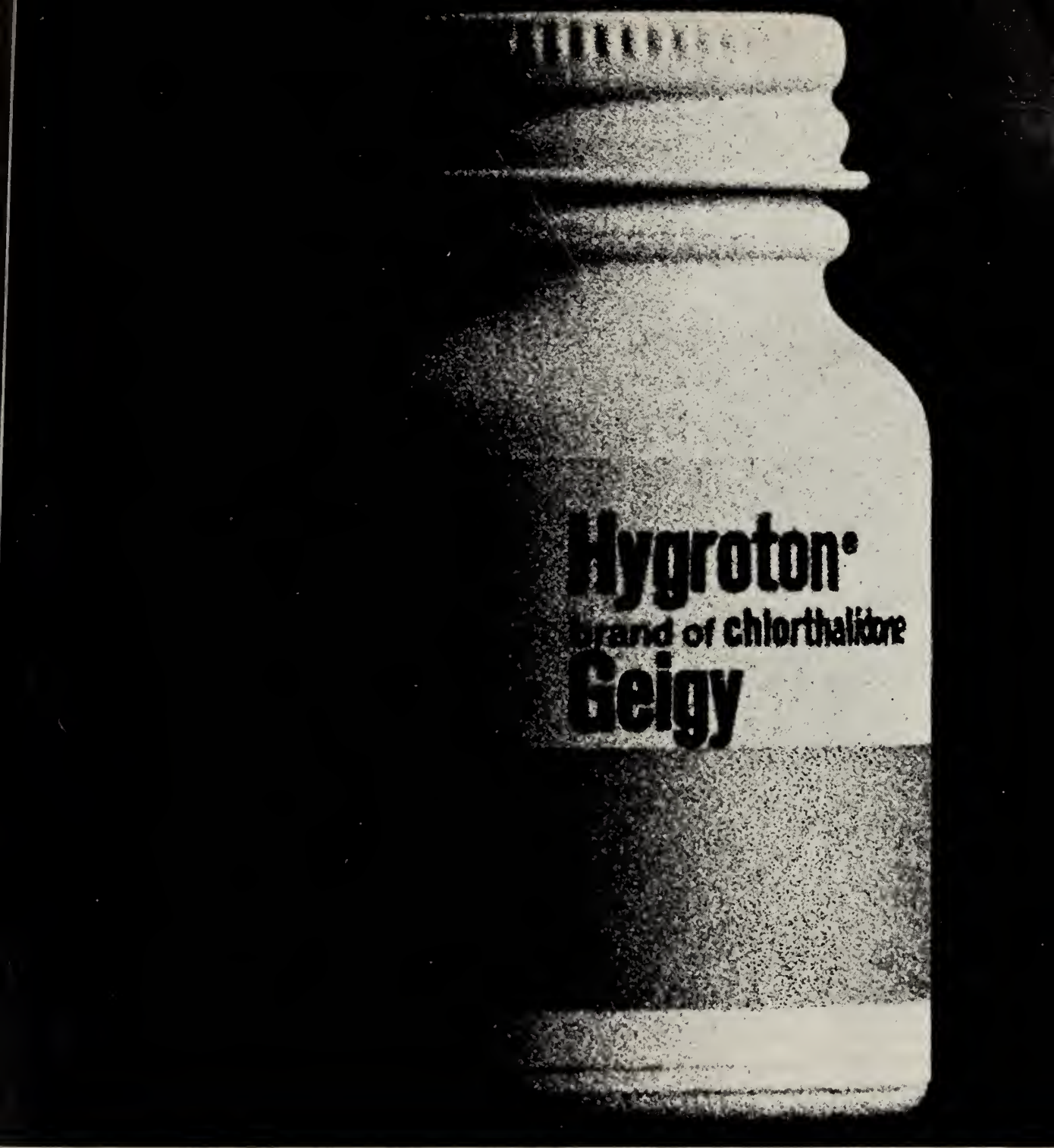
Two thousand one hundred members of MASA are members of the American Medical Association.

Description: Hygroton, brand of chlorthalidone, is an oral diuretic agent of value in the treatment of edema and hypertension. The drug is notable for its prolonged action (48-72 hours) and low toxicity. It is not a thiazide and may often be employed successfully in patients who are intolerant of other agents or become refractory to them.
Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000. For full details, see the complete prescribing information.

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brand of chlorthalidone

The long-acting diuretic

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ho needs it?

Patients with edema.
Edema in congestive heart failure.
Or in the premenstrual syndrome.
Edema in pregnancy...or obesity.
Patients you want to bring to dry weight.
And those you want to keep at dry weight.
Those you want on single daily doses.
And those requiring even fewer doses.
Those resistant to other therapy.
And those intolerant of other diuretics.
Those who have to pinch pennies.
And those who can afford the best.



Low host resistance?

Consider the "extra" antibacterial activity of Ilosone®

Occasionally, therapeutic failure is due to the patient's inability to mobilize his defenses sufficiently to overcome infection. Typical of this is the debilitated patient, the premature infant, or the diabetic. It is in these patients that the high levels of antimicrobial activity of Ilosone are especially useful. Ilosone has demonstrated antibacterial levels two to four times those of erythromycin base or stearate. Furthermore, it attains them earlier and maintains them longer. Even the presence of food does not appear to affect the activity of Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Side-Effects: Even though Ilosone is the most active oral form of erythromycin, the incidence of side-effects is low. Infrequent cases of drug idiosyncrasy, manifested by a form of intrahepatic cholestatic jaundice, have been reported. There have been no known fatal or definite residual effects. Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of patients as a result of a local stimulating action of Ilosone on the alimentary tract. Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

Dosage: *Children under 25 pounds*—5 mg. per pound of body weight every six hours. *Children 25 to 50 pounds*—125 mg. every six hours. *Adults and children over 50 pounds*—250 mg. every six hours. For severe infections, these dosages may be doubled.

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THE OUTHOUSE KID

Charles A. Isbell, M. D.

Chief Resident, Department of Pediatrics

Lloyd Noland Hospital

Fairfield, Alabama

This paper is a case presentation of a premature infant who was born in an outhouse and spent the first four hours of life among the fecal waste and lime deposits in the receptacle portion of the privy. The child survived in spite of experiencing numerous complications including severe generalized sclerema, bilateral pneumonia, and extensive necrotizing Pseudomonas infection of the scalp. The patient is discussed from the standpoint of management and therapy, particularly with respect to complications.

Introduction

Premature infants frequently pose many varied and challenging problems even under optimal conditions surrounding pregnancy and delivery. Generally speaking, they have entered an environment for which they are not completely prepared. The premature patient presented in this paper had as lowly a beginning as possible and thereby qualifies as a special case. She was born in an outhouse, and spent the first four hours of life among the fecal waste and lime deposits in the receptacle portion of the privy. The child survived in spite of experiencing numerous complications including severe generalized sclerema, bilateral pneumonia, extensive necrotizing Pseudomonas infection of the scalp, and probable congenital heart disease.

Case Report

This 4 lb. 6 oz. premature female infant was born on August 31, 1964, the twelfth child of a 33 year old Negro female. The mother knew she was pregnant, but had received no prenatal care and denied knowledge that she was in labor. She developed stomach cramps and diarrhea about three hours prior to the child's birth. While straining at defecation in a privy, she spontaneously delivered the infant into the receptacle portion approximately five feet below the toilet seat. The mother could hear faint sounds from the infant, and sought help in retrieving the baby. The county health department was notified, but they were unable to rescue the child. Finally, the baby was removed four hours after birth by firemen who dug a tunnel into the rear embankment of the outhouse. A public health nurse, who was the ranking medical attendant present, tied the cord. She reported that the infant was covered with feces, lime, and maggots, and would take only an occasional faint gasp. The baby was admitted to Lloyd Noland Hospital five hours after birth.

On admission the child was barely alive with a rectal temperature of 90°F., respira-

tory rate of 5-10/min., and a heart rate of 60-80/min. She was cyanotic, very dirty, and foul smelling and had numerous contusions and areas of excoriated skin. A moro reflex could not be elicited, and there was no cry. The baby was cleaned up immediately, given 0.25 cc caffeine sodium benzoate intramuscularly, and placed in a warm incubator with oxygen. The hemoglobin on admission was 12.4 grams. She was given 1 mg. of aqueous vitamin K, 1 cc of gamma globulin, and was started on aqueous penicillin 100,000 units and Kanamycin 15 mg. intramuscularly at 12 hour intervals.

The infant remained moribund and cold for the first 12 hours, but the temperature then gradually increased and vital signs improved slightly. At 36 hours of age, the baby developed generalized sclerema which progressed over the next 12 hours until the patient felt mummified. Adrenal corticosteroid therapy was started with administration of hydrocortisone 25 mg. intramuscularly at six hour intervals. The skin texture began to return to normal on the sixth day, and the dosage was decreased in increments and stopped after ten days of therapy.

At 48 hours of age, naso-gastric tube feedings of SMA (10 calories/oz.) were started. The child had a brief episode of apnea at this time, but responded to caffeine sodium benzoate 0.25 mg intramuscularly, aqueous adrenalin 0.1 cc 1:1,000 subcutaneously, and artificial respiration.

Following resuscitation, the patient had marked respiratory distress with intercostal retraction and very poor air exchange. Roentgenogram of the chest revealed bilateral pneumonia. Intranasal oxygen was required to keep the child alive.

On the fourth day of life the baby went into congestive heart failure and developed a grade II precordial systolic murmur for the first time. She was digitalized with oral Lanoxin over a 24 hour period and was then placed on daily maintenance therapy. By this time, a purulent conjunctivitis had developed and after cultures were obtained, local Neosporin ophthalmic ointment was instilled three times daily. The inflammation gradually cleared.

By the eleventh hospital day the child had lost 15 oz. and weighed only 3 lb. 7 oz. Several purulent lesions were noted on the scalp, and one small lesion was present on the left thigh. These skin lesions clinically appeared to be due to pseudomonas and subsequent cultures were positive for this organism. Previous systemic antibiotics were stopped and colistin sulfate 3 mg/kg/day, and sodium nafcillin were started intramuscularly. In spite of this therapy, as well as local irrigations and antibiotics, the scalp lesions progressed rapidly and within four days an area measuring 10 x 8 cm. had sloughed (Fig. 1). X-ray examination failed to show involvement of the outer table of the skull. Systemic antibiotics were given for two weeks, and then local measures only were continued. The thigh lesion granulated in and healed nicely, however, the scalp lesion closed slow-

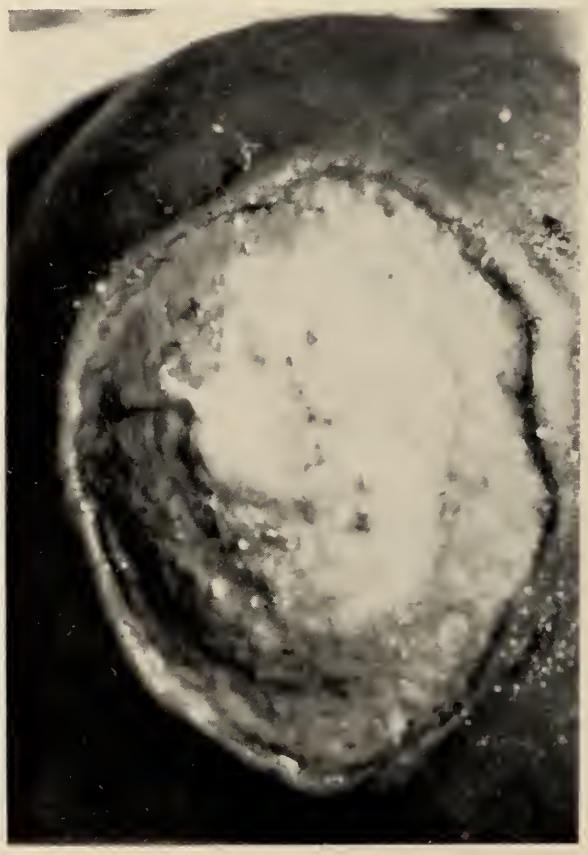


Figure 1. Scalp lesion at 15 days of age.

ly and stabilized at 4 x 2½ cm. after two months (Fig. 2). Successful split thickness skin graft from the anterior thigh to the scalp area was then accomplished under general anesthesia. The grafted area and donor site healed without further complications. The child's general condition continued to improve after surgery. Maintenance digitalis was stopped without difficulty but she was continued on multiple vitamins and oral iron.

At the age of 87 days the patient was discharged on Thanksgiving day, 1964, with a weight of 7 lb. 3 oz. and a hemoglobin of 10.8 grams. Both the mother and those who had cared for the baby were thankful that she could go home.

She was seen in the outpatient clinic at four months of age (Fig. 3). The only significant findings were the persistent heart murmur and a pterygium partially covering the cornea on the medial aspect of the right eye.



Figure 2. Scalp lesion after 2 months.



Figure 3. Infant at 4 months of age.

Comment

Part of the delay in retrieving the infant resulted from the understandable confusion associated with childbirth under such circumstances and the apparent disbelief that such could occur.

Stool cultures were obtained from the mother and from different areas of the privy. All of the cultures were reported as negative for pathogenic enteric organisms by the county health department.

The patient was placed on prophylactic antibiotics because of the extreme contamination associated with the birth. Penicillin and Kanamycin were chosen because they are considered safe and effective for antimicrobial protection in the neonate.[1] The gamma globulin was given empirically because of the patient's critical condition and because of the high risk of gram negative infection.

When the skin lesions developed after the tenth day, antibiotics were changed to sodium nafcillin as an anti-staphylococcal agent and colistin as an anti-Pseudomonas agent. Pseudomonas was suspected clinically and is resistent to most available antibiotics. Colistin sulfate has been shown to be effective against some such skin infections[2] and apparently was in this case.

Sclerema neonatorum is generally thought to be a sign of severe toxicity from some underlying disease process such as pneumonia or septicemia.[3] The mortality rate is still quite high in spite of adrenal corticosteroid therapy and antibiotics.[4]

It has been said that constant watching, expert nursing, avoidance of infection, and a true interest in premature infants are more important than expensive equipment in caring for premature infants.[5] The fact that this patient is alive today attests to the validity of this statement. The child was near death for days, but her eventual survival and recovery demonstrates that some seemingly hopeless cases can be salvaged.

Summary

A premature infant with the unique lowly beginning of being born into the receptacle portion of an outhouse is presented. The baby spent the first four hours of life in the privy and developed several complications including severe generalized sclerema, pneumonia, necrotizing Pseudomonas infection of the scalp and probable congenital heart disease. The patient is discussed from the standpoint of management and therapy, particularly with respect to complications.

The author wishes to acknowledge the assistance of all members of the Pediatric Department and the Department of Surgery, Lloyd Noland Hospital for their help in management of this patient.

Bibliography

1. Eichenwald, H. F., and Shinefield, H. R.: Antimicrobial therapy in the neonatal period. In McKay, R. J., Jr., editor: Symposium on antimicrobial therapy, Pediatric Clinics of North America 8: No. 2, 1961.

2. McMillan, M., MacLaren, D. M., Price, T. M. L., and Scott, G. W.: Pseudomonas Pyocyanea Infection treated with Colistin Methane Sulfonate. Lancet, Vol. II; 13 Oct., 1962.

3. Warwick, W. J., Ruttenberg, H. D. and Quie, P. G.: Sclerema Neonatorum A Sign, not A Disease. JAMA Vol. 184: June 1, 1963.

4. Lucin, S. E., Bakst, C. M., and Isserow, L.: Sclerema Neonatorum Treated with Corticosteroids, Brit. Med J. 2: 1933, 1961.

5. Davison, W. C. and Levinthal, J. D., The Compleat Pediatrician 8th Rev. Ed., Durham, N. C., Printed by Seeman Printery for Duke Univ. Press, 1961.

DR. TINSLEY R. HARRISON GIVEN "HONOR AWARD"

The American Medical Writers' Association conferred its highest individual honors on a medical teacher and author, and the editor of one of the nation's leading medical journals on September 25. The Association's "honor award," presented annually to a non-member who has made "distinguished contributions to medical communications," was given to Dr. Tinsley R. Harrison, Professor of Medicine of the Medical College of Alabama. Dr. Harrison was cited for "high accomplishment as a teacher, writer, counsellor and practitioner of medicine." The award was presented to Dr. Harrison on behalf of the A. M. W. A. by Dr. George G. Stilwell of Rochester, Minnesota, chairman of the A. M. W. A. Board of Trustees.

Report Of Primary Metallic Fixation In Open Fractures

a limited series by

Barry M. Green, M. D.*

Paul S. Derian, M. D.**

A review of 2425 operative Orthopedic cases from 1952 to 1964 was done to discern the use of primary metallic fixation in open fractures.

Cases

Of 2425 operative patients, nine open fractures had metallic fixation as a primary procedure. All were adult males. The age range was 23 to 49 with an average of 40.5 years. The time interval from injury to primary surgical treatment was four to 30 hours; the average was 10.5 hours. Followup was from eight weeks to six years. The remaining 2416 cases were not comparatively evaluated. The patients were from the Veteran's Administration Hospital, Jackson, Miss.

Six patients (66.7%) had no postoperative complications. All were treated conventionally with saline irrigation (no exact regimen), extensive wound debridement, metallic fixation, primary closure and antibacterial coverage. Immobilization postoperatively was with plaster fixation with the exception of case No. 3. Temporary Buck's traction was used.

TABLE I

Case	Age	Sex	Injury
1	46	M	Open fracture distal 1/3 left ulna.
2	23	M	Open fracture distal 1/3 left and right tibia and fibula.
3	40	M	Open fracture middle 1/3 left femur.
4	49	M	Open fracture distal 1/3 right tibia and fibula.
5	38	M	Open fracture talus, tarsal navicular and medial malleolus left foot.
6	42	M	Open fracture of the middle 1/3 right tibia and fibula.
7	39	M	Open fracture middle 1/3 of the right tibia and fibula.
8	42	M	Open fracture distal 1/3 of the left tibia and fibula.
9	45	M	Open fracture distal 1/3 of the left tibia and fibula.

Case 9 (open fracture distal 1/3 left tibia and fibula) became infected 13 days postoperatively; the organism was beta hemolytic streptococcus. He was treated with specific antibacterial agents and drainage. Spontaneous wound healing occurred. No secondary closure was necessary.

Case 7 (open fracture middle 1/3 right tibia and fibula) developed a postoperative

*Resident, Orthopedic Surgery, University of Mississippi Medical Center, Jackson, Mississippi.

**Chief, Orthopedic Surgery, University of Mississippi Medical Center, Jackson, Mississippi.

TABLE II

Case	Injury to Surgery	Primary Treatment
1	Less Than 24 hours	Irrigation and debridement. Intramedullary fixation kirschner wire ulna left. Primary closure long arm cast. Penicillin and aureomycin postoperatively
2	Less than 24 hours	Irrigation and debridement. Open reduction and fixation (Eggers plate) tibia fracture left. Primary closure. Long leg cast. Penicillin and terramycin postoperatively.
3	4 Hours	Irrigation and debridement. Intramedullary fixation Hansen Street Nail femur left. Metallic screw fixation medial condyle. Primary closure. Penicillin and Chloromycin postoperatively.
4	5 Hours	Irrigation and debridement. Open reduction and fixation 3 metallic screws tibia right. Primary closure. Long leg cast. Penicillin and erythromycin postoperatively.
5	30 Hours	Irrigation and debridement. Fixation with metallic screw medial malleolus left. Primary closure. Short leg cast. Chloromycetin and terramycin postoperatively.
6	9 Hours	Irrigation and debridement. Intramedullary fixation Lottes nail tibia right. Primary skin closure. Long leg cast. Penicillin and Chloromycetin, postoperatively.
7	7 Hours	Irrigation and debridement. Intramedullary fixation Lottes nail tibia left. Primary closure. Long leg cast. Chloromycetin and terramycin postoperatively.
8	7 Hours	Irrigation and debridement. Fixation (Egger's plate) 4 metallic screws tibia left. Long leg cast. Chloromycetin and erythromycin postoperatively. Primary closure.
9	5 Hours	Irrigation and debridement tibia left. Fixation two metallic screws. Primary closure. Long leg cast. Chloromycetin and erythromycin postoperatively.

infection (staphylococcus aureus coagulase positive) 14 days after surgery. The wound was opened, drained and antibacterial agents given. Secondary healing resulted.

Case 5 (open fracture talus, tarsal navicular and medial malleolus left foot, shotgun wound) required a Syme's amputation when an uncontrolled postoperative wound infection developed; followup care in case 1 was inadequate for discernment by bony union. The organism was pseudomonas aeruginosa.

Discussion

In a review of the literature, two articles were found to be of interest. In 1952 Rush, Fitts and Gibbon[2] reported experimental work of intramedullary nailing in the presence of infection. Identical fractures of ten mongrel dogs' ulna were done bilaterally and grossly contaminated. Unilateral intramedullary nailing using a Kirschner wire was done. In the opposite leg no wire was inserted. In eight of the ten dogs, healing was more rapid and infection was less severe on the pinned side. In no instance did the presence of the Kirschner wire cause spread of the infection through the medullary cavity. The dogs were given antibiotics postoperatively. The series was limited and statistically sufficient for an observation. A larger experimental study should be done.

In 1957 Brau[1] reported intramedullary nailing in the treatment of 70 gunshot fractures during the Korean War. **None** were treated by nailing at the time of primary wound debridement. Twenty-eight were nailed prior to wound healing; 25 (89.3%) had satisfactory results. Another group of fractures were treated by immediate or slightly delayed wound closure; 14 (87.5%) were satisfactory. Eleven (91.7%) of another group treated with wounds open following nailing, had satisfactory results; 37 (88.1%).

All nine cases were placed on antibacterial agents postoperatively. The use of a broad spectrum antibacterial agent did not have a discernible alteration with regards to an infected wound. Unfortunately no cultures were taken prior to and after debridement of the wounds.

TABLE III

Case	Infection and Organism	Antibacterial Agent After Infection	End Results
1	None	None	8 weeks follow-up
2	None	None	4 months beginning union
3	None	None	Complete union
4	None	None	Complete union
5	Wound infection. 10 days post-operative osteomyelitis pseudomonas aerogenes.	Chloromycetin Declomycin	Syme's amputation 25 days post injury. Subsequent wound healing.
6	None	None	Complete union
7	Wound infection 14 days postop Coagulase positive Staphylococcus	Tetracycline Chloromycetin	Complete union
8	None	None	Complete union
9	Wound infection 13 days postop hemolytic streptococcus Staphylococcus epidermis	Chloromycetin Erythromycin	Complete union

Summary

(1) A review of 2425 consecutive Orthopedic surgical procedures from the Veteran's Administration Hospital, Jackson, Mississippi, was done.

(2) Although the authors do not agree with the selection of Kirschner wires or Eggers plates, the principle of placing metal in an open wound and their effectiveness was considered.

(3) Nine open cases had primary metallic implants.

(4) 66.7% had good to excellent results (6 patients).

(5) 33.3% (or 3 of 9 patients) had a postoperative infection. One of the 9 required amputation.

(6) No decision as to the handling of an open wound with primary metallic fixation was made for the number of cases was small.

(7) Future selective cases for the establishment of a basic criteria should be done.

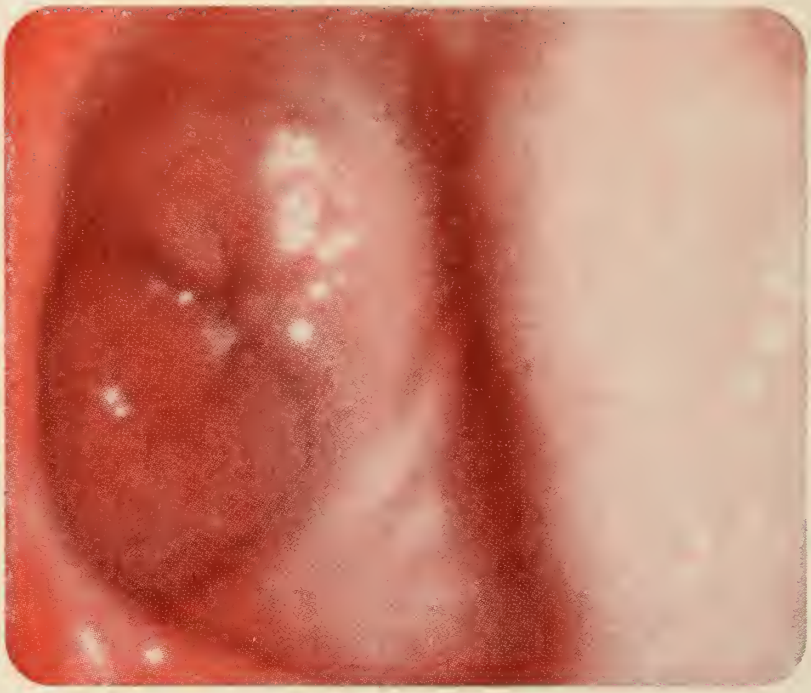
Bibliography

1. Brau, E. A.: Further Evaluation of the Use of Intramedullary Nailing in the Treatment of Gunshot Fractures of the Extremities, *Journal of Bone and Joint Surgery*, 39A: 513, 1957.

2. Rush, H. L., Jr., Fitts, W. T., Jr., Gibbons, J., Monroe, E.: Intramedullary Nailing in the Presence of Infection, *Surgery Gynecology and Obstetrics*, Vol. 94: 727, 1952.

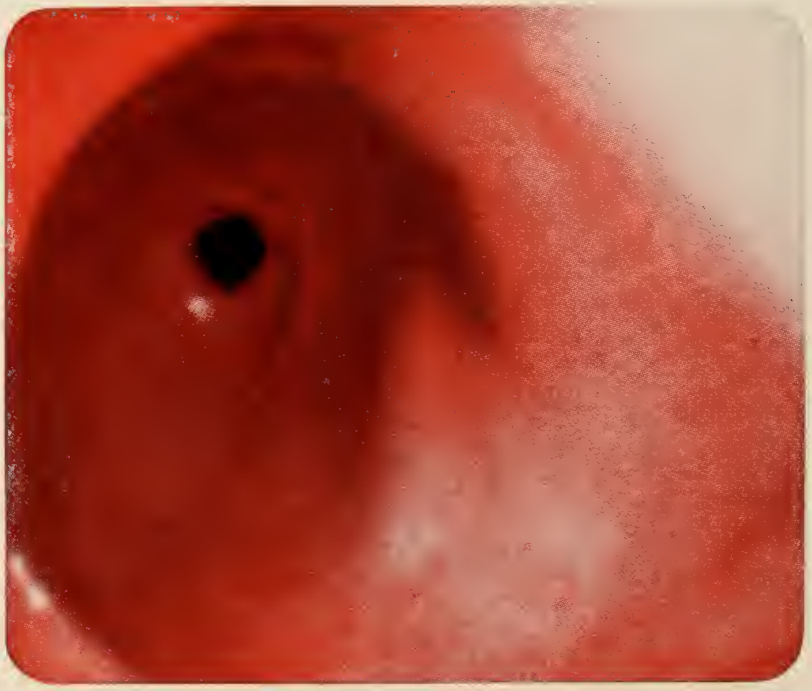
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Intragastric photography studies[1]



A/ E. B., male, age 48. Normal antral contraction. Pyloric opening is not seen. It is difficult to differentiate a deep prepyloric contraction from a "pyloric fleurette" or true pylorus.

B/ Same subject after 6 mg. of propantheline bromide intravenously; antral contractions ceased. The pyloric orifice remained open and was easily identified. Better visualization of the antrum was also obtained.



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1. Barowsky, H.; Greene, L., and Bennett, R.: Investigators' Clinical Report. Photographs courtesy of Drs. H. Barowsky, L. Greene and R. Bennett.

2. Barowsky, H.; Greene, L., and Paulo, D.: Paper read at Meeting of American Society for Gastrointestinal Endoscopy, Montreal, Canada, May 25-27, 1965.

SEARLE

Research in the Service of Medicine

MATERNAL AND CHILD HEALTH

A continuous state-wide Maternal and Infant Health Study is being conducted in Alabama by the Committee on Maternal and Child Health of The Medical Association of the State of Alabama in cooperation with the Alabama Department of Public Health and assisted by official representatives of the various County Medical Societies of the state.

This is the second in the series.

POSTPARTUM HEMORRHAGE

By James H. French, M. D.

Until the early part of this century, the maternal mortality rate throughout the world was extremely high. Due to better comprehension of the causes of maternal death and to dedicated efforts of medical educators, a rapid decrease in this rate occurred. However, for the past few decades little progress has been made in reducing the maternal mortality rate. Throughout this country maternal mortality studies have been conducted during these decades. In some states, financing is such that studies in depth have been made. From these studies and from our own studies in Alabama, we hope to be able to stimulate enough interest to reduce maternal mortality to a minimum number of preventable deaths. We are far from this ideal now. From case summaries compiled through the co-operation of local physicians, pathologists, the State Department of Public Health, and at times volunteer unpaid investigators, it appears that many maternal deaths are still preventable. Ideally all patients should receive adequate prenatal care and should be delivered in a hospital under adequate medical supervision.

Postpartum hemorrhage is one of the major causes of maternal deaths in Alabama. Many of these are preventable. Most of these seem to be associated with midwife deliveries or with medical or obstetrical complications. A recent case summary which we received indicated that after a relatively normal prenatal course, labor and delivery, a mother bled to death while the happy midwife was busy showing the newborn infant to the family. Another summary indicated that a midwife encountered excessive bleeding while awaiting the delivery of the placenta. The first physician she called sent medication. The second physician she called responded by coming to the patient's bedside. He examined her and called an ambulance. When she arrived at the emergency room, the placenta was removed just as the patient expired from shock from blood loss. There was too great a time lapse from the recognition of a complication until the complication was dealt with. These studies cannot help these patients. They may help us to plan preventive measures to help lower the maternal mortality rate for the future.

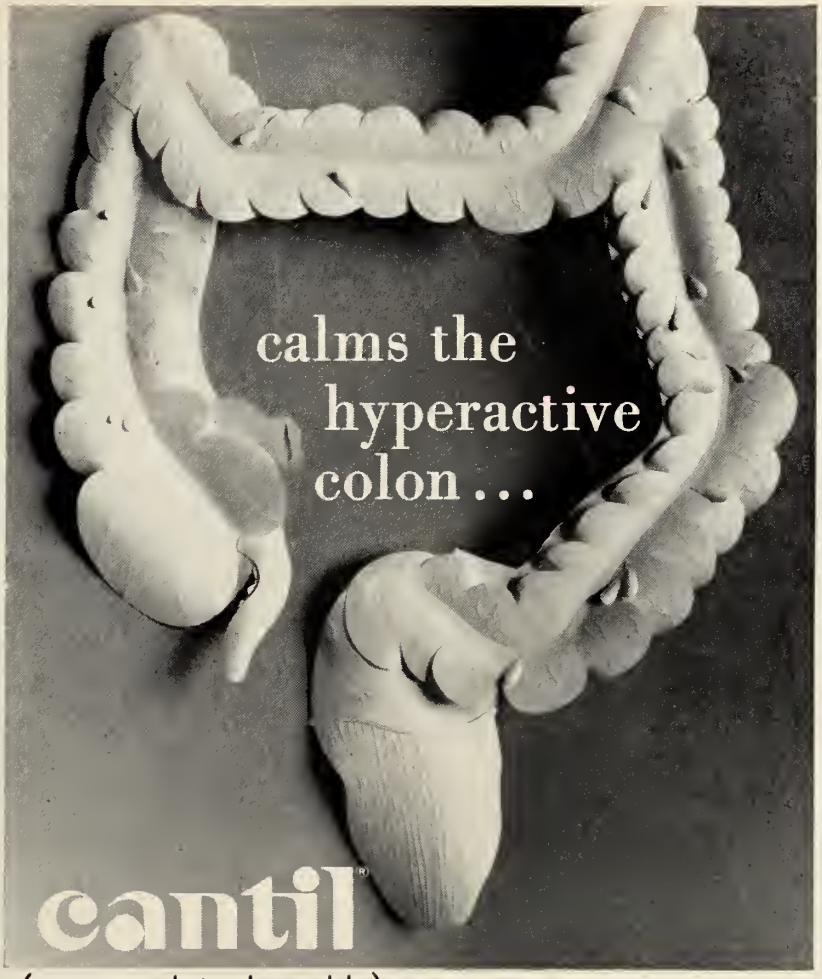
Definition:

Immediate postpartum hemorrhage is usually considered the loss of more than 500 cc's of blood either associated with delivery or in the puerperium. A late postpartum hemorrhage may occur even several weeks after delivery.

Etiology:

Postpartum hemorrhage comes from lacerations in the birth canal or from the placental site. Small arteries in a laceration may retract and remain a source of bleeding. Blood loss from the placental site may be due to the uterus failing to contract well around the placental site or from defects in clotting. A fragment of placenta may hold sinuses open allowing bleeding to continue. Uterine atony

(Continued on Page 440)



(mepenzolate bromide)

helps restore normal motility and tone

Cantil (mepenzolate bromide) works in the colon. In irritable colon, spastic colon, ulcerative colitis and other functional and organic colonic disorders, it acts to:

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IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

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1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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(Continued from Page 438)

often follows short tumultous labor or prolonged exhausting labor. The presence of uterine overdistention by multiple pregnancy or by polyhydramnios predisposes to atony. Tumors distorting the uterus sometimes prevent adequate or effective control of blood loss from the placental site. Postpartum shock from any cause results very soon in uterine relaxation. Rupture or inversion of the uterus as a cause of hemorrhage must not be ignored.

Late postpartum hemorrhage is usually the result of infection and retention of secundines.

Prevention of postpartum hemorrhage:

Prevention starts with educating the patient and the doctor as to the value of adequate prenatal care. Only through this means can the patient be brought to term pregnancy in optimum physical condition with her risks evaluated and conditions prepared to meet her individual problems. This may mean Cesarean section for the patient with the uterine scar, or it may mean only the knowledge of the location of emergency help and equipment in case it is needed. Use of sedation, stimulation, and intravenous fluids during labor as indicated to keep the patient in good condition will prevent maternal exhaustion and hemorrhage. During delivery good obstetric judgment guides the physician between foolish meddling and wise assistance to the patient. Certainly no patient who is not in optimum condition should have a home delivery. Whenever home delivery is allowed, communication between the midwife and doctor should insure immediate hospital care if complications appear.

In spite of good technique, lacerations occur and difficult deliveries are accomplished. Careful observation after delivery and meticulous repair of lacerations on the first attempt saves blood loss.

Treatment of postpartum hemorrhage:

When blood loss after delivery is more than the usual small trickle, it is wise to re-examine the placenta for missing fragments and to inspect the repair for retracted bleeding vessels and previously unseen laceration or rupture of the uterus. Where placental site bleeding occurs, the use of more oxytocic, perhaps as an intravenous drip, while holding the compressed uterus between the two hands, may control the flow. Where this is ineffective, clamping the base of the broad ligaments with sponge forceps to compress the uterine arteries has been suggested. Some authorities advise uterine packing. This controls venous bleeding but can obscure major blood loss as it is absorbed into the packing. There is much said for and against packing. In the very rare case, a hysterectomy must be done. While the physician is busy with the above procedures, blood can be obtained and started. Laboratory work to determine clotting characteristics may be started, beginning with the observation of whether the blood that the patient has lost has clotted at the delivery table. Where indicated, fibrinogen is given.

Late postpartum hemorrhage often responds to an intravenous drip of pitocin along with blood transfusions if indicated, and with antibiotics. Where this does not control the bleeding, a D & C and packing usually will control it. Hysterectomy is practically never necessary unless uterine rupture is discovered.

In summary, with today's increased medical knowledge and facilities, with today's rapid means of communication and transportation, it is difficult to understand why we should be content with leaving maternal mortality as it is. Distribution of neighborhood hospitals which are well equipped make modern facilities available to patients throughout the state. It seems that with a little more planning, a little better communication, a few dry runs at frequent intervals to keep the doctor and hospital on the alert and able to cope with the multiple problems which are always present when hemorrhage occurs, we should be able to make death from maternal hemorrhage non-existent.



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to help relieve pain in common anorectal disorders

"non-caine" Diothane®

Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form...both are now available.

DIOTHANE OINTMENT

COMPOSITION:
diperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:
Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.





DIOTHANE SUPPOSITORIES

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215/Weston, Ontario



The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—Federal agencies relaxed regulations for sale of Ipecac, ordered warning labels on certain antihistamines, and cracked down on two patent medicines.

The Food and Drug Administration decided that ready availability of Ipecac as a poison remedy outweighed the dangers of possible misuse and placed it back on the list of drugs for sale over the counter without a prescription.

Since Ipecac was placed on a prescription-only basis in January, 1964, the American Medical Association, the American Academy of Pediatrics, and the Association of Poison Control Centers had urged that the vomit-inducing drug be returned to its former status.

Under the new FDA ruling, FDA's Bureau of Medicine told the Pediatrics group in Chicago that FDA decided it would be in the public interest to permit Ipecac to be sold over the counter in one-fluid-ounce bottles with special warnings on dangers of its misuse.

The FDA also ruled that in the future antihistamines containing meclizine, cyclizine and chloro-cyclizine must bear labels warning against use by pregnant women without medical advice. However, they were left on the over-the-counter list. The FDA said massive doses of these drugs in test animals had produced congenital abnormalities, but there had been no evidence they have caused abnormalities in human babies.

Chas. Pfizer & Co., Inc., one of the companies that manufacture such antihistamines, protested the decision as not being "in accordance with the medical facts."

A House Government Operations Subcommittee headed by Rep. H. L. Fountain (D., N. C.) recently had criticized the FDA for its handling of these antihistamines, contending that stronger warnings were needed and indicating that they should be prescription items.

The FDA ordered a halt to the sale of Alergimist "A" and "B", widely advertised as "cures" for hayfever, bronchial asthma, migraine headaches and allergic dermatitis.

The product has been actively promoted through newspaper, radio and TV ads without having been passed by the agency as either safe or effective. The product, sold without a prescription, was being distributed by the Brunson Corporation of Miami Springs, Fla. FDA said the same concern previously distributed Allergimist (with two "l"s) until an injunction in September, 1964, was obtained against its interstate shipment.

The Federal Trade Commission ordered the J. B. Williams Co. of New York City to stop allegedly misrepresenting the effectiveness of "Geritol" liquid and tablets. The Commission ruled that Geritol television commercials and newspaper advertisements falsely represent that all cases of tiredness, loss of strength, run-down feeling, nervousness and irritability indicate a deficiency of iron and that the common, effective remedy for these symptoms is Geritol.

Geritol is not beneficial except in the small minority of persons whose tiredness symptoms are caused by a deficiency of iron or one or more of the vitamins contained in the preparation, the FTC said.

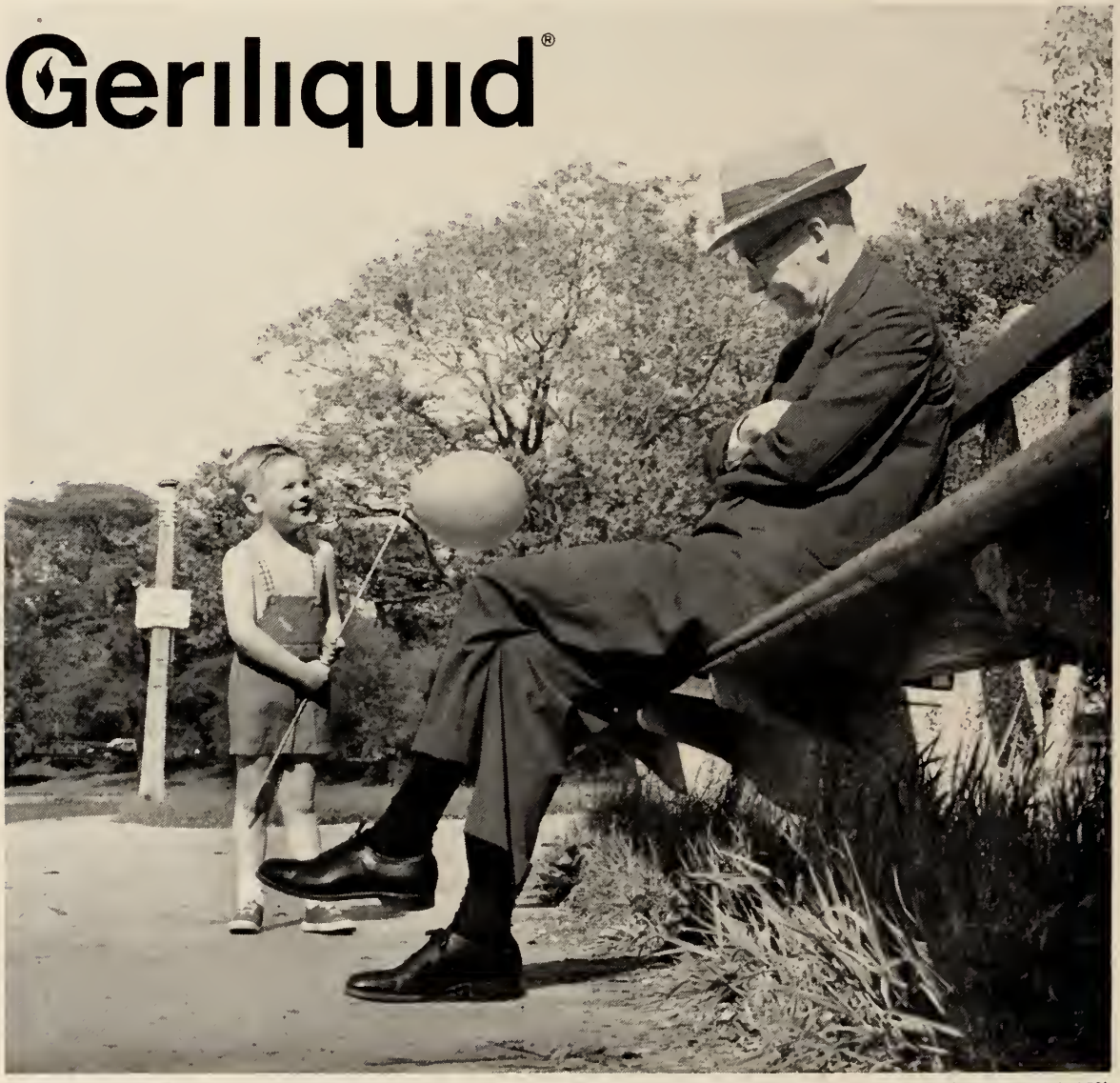
(Continued on Page 449)

when even southern sun fails to warm cold hands and feet

provide rapid, sustained vasodilation for warmth and relief of pain, dizziness and faintness in patients with impaired peripheral circulation

GERILIQUID warms cold hands and feet through the thermogenic action of glycine and through sustained vasodilation by glycine and niacin. In addition, in patients with impaired peripheral circulation, GERILIQUID increases the ability to walk farther with less pain. Patients particularly like the palatable, sherry wine base.

Geriliquid®



IN BRIEF: Composition: Each 5 ml. contains: niacin 75 mg. and aminoacetic acid (glycine) 750 mg. in a palatable sherry wine base; alcohol 5%.

Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.

Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.

Supplied: Bottles of 8 oz. and 16 oz.

LAKESIDE LABORATORIES, INC.

Milwaukee, Wisconsin 53201



If the dealer, North, is 46 yrs. old and West is 42 and East is 39 and South is pregnant, who has biliary dysfunction?

They're all vulnerable.

Patients approaching middle age, as well as pregnant women who complain of "irregular" constipation, belching, flatulence and indigestion with no evidence of organic disease may be suffering from functional disturbances of the biliary tract.

These basic disturbances can often be corrected by a single convenient and effective medication: Neocholan.

Neocholan is more than a laxative. It combines all the ingredients for the total management of functional biliary stasis in one tablet. Dehydrocholic acid stimulates the production of thin, free-flowing bile. Bile salts promote better digestion to absorb fats and fat-soluble vitamins, and they tend to prevent chronic constipation by maintaining intestinal tone and normal peristalsis. Phenobarbital and homatropine methyl bromide relax intestinal spasm and insure unobstructed passage of bile and pancreatic juice into the duodenum.

Neocholan is contraindicated in patients with glaucoma. Use cautiously in elderly patients with urinary retention and reduce dosage if blurring of vision, increase in pulse rate, or distressing dryness of the mouth result.

Each tablet contains Dehydrocholic Acid: 250 mg. (3¾ gr.); Bile Extract (Porcine): 15 mg. (¼ gr.); Phenobarbital: 8.0 mg. (⅛ gr.) (Warning: May be habit forming.); Homatropine methyl bromide: 1.2 mg. (1/50 gr.).

Neocholan®

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana DOW



Lirugen™

is *truly* a one shot measles vaccine.

Lirugen is the most highly attenuated, but fully antigenic, live measles vaccine (Schwarz Strain).[1-8] Additional special passages of the Edmonston Strain resulted in further attenuation which reduces systemic reactions so effectively that the use of gamma globulin with Lirugen is not needed. In recent clinical trials, Lirugen was administered without gamma globulin to approximately 13,000 children. In 1,405 of these children tested serologically, a conversion rate of 99% was reported. Close medical follow-up of inoculated children and controls showed no significant differences between mean maximum temperatures in the two groups. The incidence of high fever (103°F and above, rectally) attributable to the vaccine could be calculated at less than 1%, and the occurrence of mild, transient rash at less than 3%.

Contraindications: Pregnancy; leukemia, lymphoma and other generalized malignancies; brain damage in children under one year of age; febrile illness; allergy to egg proteins, neomycin, or streptomycin. Precautions: Use cautiously in patients with a history of tuberculosis and patients being treated with steroids, irradiation, alkylating agents, and antimetabolites. Consult package literature before administering Lirugen.

References:
1. Schwarz, A.J.F.: Amer. J. Dis. Child., **103:** 386-389, 1962.
2. Krugman, S. et al.: Pediatrics, **31:** 919-928, 1962.
3. Andelman, S. L. et al.: J.A.M.A., **184:** 721-723, 1963.
4. Measles Vaccines: W.H.O. Technical Report Series No. 263, 1963.
5. Schwarz, A.J.F.: Annales Paediatrici, **202:** 241-253, 1964.
6. Morley, D. C. et al.: Bull. W.H.O., **30:** 733-739, 1964.
7. Andelman, S. L. et al.: Scientific exhibit at annual meeting of The American Academy of Pediatrics, 1964.
8. Krugman, S. et al.: J. Pediatrics, **66:** 471-488, 1965.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, U.S.A. Dow



"Is my sweep weak?"

If it is, it will soon be gone, and that fine cardioscope will be of no use. Call us and it'll sweep clean, like a new broom.

Our scheduled maintenance service keeps equipment in good condition. It's available at very low cost, for everything from autoclaves to x-ray machines.

We can change weak sweeps to years of sweet weeks. Let us show you how.

Yes, I'm interested in good equipment maintenance. Send a good man and we will talk it over.

Name: _____

Address: _____

City: _____ State: _____ Phone: _____

Cut Out and Mail To

General Surgical Supply Company

P O BOX 252 • 1630 6TH AVENUE SOUTH

BIRMINGHAM, ALABAMA **Phone 251-4176**

WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: **ACTIONS AND USES:** A single dose ot Imteron (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specitically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deticiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transtusion *as a source of iron;* intants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITIDN: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.D. The 10 cc. vial contains D.5% phenol as a preservative.

ADMINISTRATIDN AND DDSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. ot blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and tever have occasionally been reported. Initial test doses ol 0.5 cc. are advisable.

PRECAUTIDNS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran Injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of Iron deticiency anemia only, it is contraindicated in other anemias.

CARCINOGENICITY PDTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imteron (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes ot 4; 10 cc. multiple dose vials.

in iron deficiency anemia for rapid and predictable replacement of iron reserves

imferon®

(iron dextran injection)



LAKESIDE LABORATORIES, INC. • Milwaukee, Wisconsin 53201

(Continued from Page 443)

More and farther-reaching health legislation was enacted into law this year than ever was acted upon by a previous Congress.

Medicare and the heart disease, cancer and stroke programs topped the list of such legislation enacted into law, but there also were other important new health programs authorized. Several existing ones were expanded.

Approved health legislation included:

—A $787 million aid program for medical, pharmaceutical and other health schools. It authorized for the first time federal scholarships for students and operating funds for medical schools.

—A $105 million program of aid for medical libraries.

—A $250 million, three-year extension of grants for construction of health research facilities.

—Authorization of strict Federal controls on manufacture and sale of barbiturates and amphetamines.

—Requirement that cigarette packages, beginning Jan. 1, 1966, carry a health hazard warning.

—Extension of the vaccination program and expansion of it to include measles.

—Annual appropriation of a record $1.2 billion for the National Institutes of Health.

—Three new assistant secretaries of Health, Education and Welfare—one for health affairs.

—A four-year $92.5 million program of aid to municipalities for construction of garbage disposal plants and research in the field.

—Greater Federal powers in the water pollution field and $300 million to help communities build sewage plants.

—New Federal powers to control air pollution, including requirement that new autos have devices to reduce exhaust fumes.

—Expansion of the Federal vocational rehabilitation program, including $300 million in grants for building and initial staffing of rehabilitation facilities and workshops.

—A four-year, $173 million program for initial staffing of community health centers.

—An Administration on Aging in the Health, Education and Welfare Department.

—Appropriation of $157 million for Project Headstart—nursery school training and medical examinations of pre-grammar school children from low-income families.

—A $69 million hospital program for the Appalachia area.

—Automatic rank of lieutenant general or vice admiral for surgeons general of the army, navy and air force.

—Extension for three years of the program of grants for health services for domestic migrant agricultural workers.

—A one-year extension of program of grants for general health aid and for community health services.

* * *

Community vaccination programs against measles have been recommended by the Surgeon General's Advisory Committee on Immunization.

In extending the Federal vaccination program for polio, diphtheria, tetanus and whooping cough, Congress this year expanded it to include measles.

The Committee said that measles is one of the most important causes of serious illness in children and recommended that continuing "maintenance" programs aimed at vaccinating children about one year of age be established in all communities.



approximating the diuretic efficacy of meralluride

METAHYDRIN®

(trichlormethiazide)

To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin® (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

Alabama Department of Public Health

GOVERNOR AUTHORIZES HEALTH DEPARTMENT TO BE RESPONSIBLE FOR MEDICARE

Ira L. Myers, M. D.

State Health Officer

Governor George C. Wallace has designated the State Board of Health as the agency to carry out the functions of the health insurance for the aged and medical assistance portions of the amended Social Security Act in Alabama. This agency is also charged with the administration of the supplementary plan for voluntary medical insurance included in the new legislation.

The State Board of Health was already authorized by the Alabama Legislature to contract with the United States Government in regard to the operation of hospitals and related facilities. It is also the licensing authority in Alabama for hospitals and other health facilities.

In delegating this new authority, the Governor stated, "I do specifically find that the problems of the aged are serious problems in Alabama and that a program to provide a hospital and supplementary medical insurance program is required for their welfare. I further find that the State Board of Health is qualified, both by Alabama law and by experience, to carry out the functions required . . . and that it is the appropriate State agency to do so."

The basic hospital plan to be administered consists of contributory insurance protection for persons aged 65 and over against the costs of hospital and related care. Beginning in July, 1966, as part of the social security system, the plan is financed through a new special earnings tax paid by employers, employees, and the self-employed. The hospital insurance tax contributions go into a trust fund kept entirely separate from other funds of the social security system. The cost of benefits for aged people not insured under the railroad retirement or social security systems will be paid from General Funds of the Treasury.

The basic insurance plan covers up to 90 days per duration of illness for inpatient hospital services. For these services the patient pays $40 deductible and an additional $10 a day after the first 60 days. The plan covers up to 190 days of psychiatric hospital services during a lifetime. Up to 100 days of post-hospital extended care per duration of illness after hospitalization is provided, with the patient paying $5 a day after the first 20 days. The basic plan includes up to 100 home visits by health workers, with the patient under the physician's care after hospitalization. Outpatient diagnostic services are available with a deductible of $20 and 20 per cent of the cost above that for services rendered in a 20-day period.

The voluntary supplementary insurance plan provides medical insurance adminis-

(Continued on Page 453)

the price of "success"

190/102

Hypertension has been called the price of success... and in some life-situations, the cost of failure. In either event, Metatensin lowers blood pressure, cushions the patient against stress and retards the progress of disease. Metatensin is effective and economical. It is well-tolerated over long periods.

THERAPY
YOU CAN STAY
WITH

METATENSIN®

EACH SCORED TABLET CONTAINS:
Metahydrin® (trichlormethiazide) 2 mg. or 4 mg. Reserpine 0.1 mg.

In Brief: Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery. Contraindications are complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.
Supplied: Metatensin tablets, 2 mg., 4 mg. — bottles of 100 and 1000.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

(Continued from Page 451)

tered through private carriers to all residents of the United States aged 65 and over. People who enroll initially pay monthly premiums of $3 with a matching $3 monthly premium per enrollee to be paid from the General Funds of the Treasury to help finance the supplemental plan.

Beginning in July, 1966, and subject to a $50 deductible to be paid by a patient in a calendar year, the supplementary plan would cover 80 per cent of the patient's bill above the deductible for a number of services. This would include physicians' services in and out of the hospital; outside the hospital psychiatric treatment, with payment in a calendar year limited to the smaller of $250 or half of the expense; and up to 100 home health visits in a calendar year with prior hospitalization not necessary. Other medical services are also covered such as diagnostic tests, radiation therapy, medical supplies, ambulance services, and the rental of medical equipment. The Governor gave the State Board of Health "any other powers that may be convenient to it" in administering the above insurance programs. He ordered all agencies and individuals involved in the government of Alabama to plan and co-operate with the State Board of Health so that it may execute the duties imposed on it. He further gave the State Board of Health the power to make reasonable rules and regulations which will be useful in carrying out the requirements of this Executive Order.

Direct policy and procedure manuals for the administration of this new law have not yet been received from Washington. As a result it will take time for the state agencies involved to implement this new legislation. Much coordination and co-operation will be necessary before the program can be instituted as the new law and regulations specify.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

October 1965

Examination for intestinal parasites	1,245
Typhoid cultures (Blood, feces, urine and other)	345
Examinations for malaria	3
Examinations for gonococci	2,037
Serologic tests for syphilis (blood and spinal fluid)	25,702
Darkfield examinations	2
Agglutination Tests	3
Examinations for diphtheria bacilli and vincent's	265
Complement fixation tests	324
Examinations for Negri bodies (smears and animal inoculations)	200
Water examinations	2,460
Milk and dairy products examinations	4,005
Examinations for tubercle bacilli	3,697
Miscellaneous examinations	9,158
	49,446

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

Current Morbidity Statistics

1965

	Sept.	Oct.	*E. E. Oct.
Tuberculosis	111	144	139
Syphilis	183	164	117
Gonorrhea	389	459	313
Chancroid	2	1	1
Typhoid fever	1	2	3
Undulant fever	0	0	0
Amebic dysentery	4	4	3
Scarlet fever & strep. throat	229	350	69
Diphtheria	0	0	8
Whooping cough	9	2	13
Meningitis	6	6	5
Tularemia	0	0	0
Tetanus	0	2	1
Poliomyelitis	0	0	4
Encephalitis	0	0	1
Smallpox	0	0	0
Measles	24	16	28
Chickenpox	2	2	3
Mumps	3	8	19
Infectious hepatitis	39	31	56
Typhus fever	0	0	1
Malaria	0	0	0
Cancer	686	728	623
Pellagra	0	1	0
Rheumatic fever	12	15	17
Rheumatic heart	15	25	23
Influenza	31	150	30
Pneumonia	182	232	143
Rabies—Human cases	0	0	0
Pos. animal heads	1	0	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

VICTIMS OF MYTHS

(The following is an article that appeared in the Los Angeles Times on July 16, 1965 and was written by Barry Goldwater, the Republican Nominee for President in the last election. It is presented in its entirety.)

Doctors are opposed to government health plans because they don't want poor people to have "free" medical attention.

Businessmen are opposed to government spending because they don't want poor people to have anything "free."

These are just two of the silly myths spawned by a generation of welfarism.

Let's start with the doctors. They have been giving free treatments to Americans since the first frontier sawbones patched up the first penniless pioneer with an Apache quill in his jeans.

Doctors have instituted health insurance plans, established free clinics and invested their money into hospitals. Some doctors get rich, just as most men do who work as hard.

But it is an idiotic lapse of logic to say that doctors oppose medical care as such because they oppose the government's plan for medical care.

Medical care is their business, and the government's plans for medical care will not rob them of fees. Their opposition to the government's plan goes quite beyond that.

The opposition is generally based on the fear that this is just the beginning, that a disastrously regimented form of socialized medicine is the next step. No form of socialized medicine so far has been able to avoid the progress-stopping stultification that red tape inevitably brings with it.

American doctors, who have brought us the highest level of health care in the world, are rightfully concerned by this red tape spectre.

Secondly, opposition comes of another experience. What happens when medical care costs are added heavily to a Social Security system? France tried it, and their entire system is on the verge of bankruptcy as a result.

And doctors are not alone in criticizing the fiscal folly of the government's medical program.

None of the opposition, however, has anything to do with wanting to deprive anyone of needed care. To the contrary, the opposition is based upon realization that red tape can only strangle such an effort and that, in the long run, the saddest victims will be the very people the scheme sets out to help. Certain politicians will be the only ones who benefit.

The myth about coldhearted businessmen is every bit as silly. These men depend upon widely circulated incomes to keep business itself going. No one in business is helped by keeping people poor. If the income of everyone in the country could be doubled, business would double. It's as simple as that.

Many businessmen oppose government "giving" because every single time it "gives" it is the direct result of having first "got." The money it gives to one person is taken from another. There is no such thing as a free lunch—someone always pays.

Income in the business world is distributed on the basis of how hard and how well you work or build or plan. But when a politician passes out money the basis may be for any reason at all, including partisan advantage. No matter what the reason, however, the giving of money is a poor substitute for the earning of money.

Money earned in a productive job is true business expansion. Money given away is nothing but a drain on available resources.

Businessmen, as doctors, aren't against government schemes because they don't want to help the aged or the poor. It's exactly the reverse. They want to help cure poverty, as the doctors want to cure disease, with the creation of the conditions of genuine good health, not with temporary patent medicines.

(Worcester, Mass., Medical News)

a rapid lift from the hell of depression



Doré Illustration
from
Dante's Inferno

often relieves mental pain in 2-5 days

NORPRAMIN®
(desipramine hydrochloride)

Norpramin is a rapid-acting specific drug for the treatment of depression. Depressive signs and symptoms—sometimes described as "mental pain"—typically begin to improve in 2-5 days. Patients are more hopeful, less empty and less weighed down by their troubles. Norpramin has only slight sedative qualities, nevertheless anxiety *secondary to depression* is frequently relieved as depression is lifted. If anxiety or tension persists it can be controlled by adding a tranquilizer or by reducing dosage. Norpramin is not a MAO inhibitor. Side effects are usually mild.

DOSAGE AND ADMINISTRATION

Optimal results are obtained at a dosage of about 150 mg./day—two 25 mg. tablets t.i.d. After achieving optimal results, a maintenance dose (50-100 mg./day) should be sought.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

IN BRIEF:

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

Contraindications and Precautions: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established.

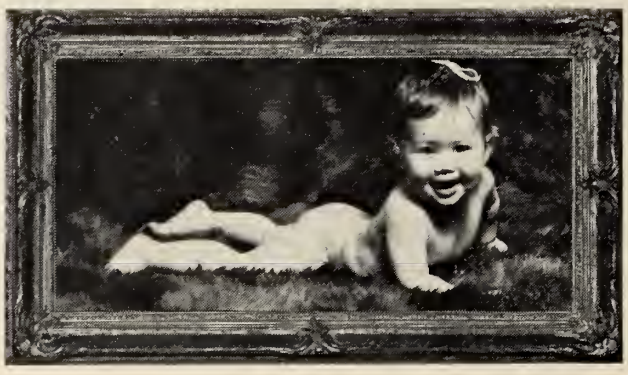
Adverse Effects: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

Supplied: Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

Turn a bundle of colic

into a bundle of joy







COLIC, often in part a reflection of family tension, adds sleepless nights to patients' and parents' distraught days. Pediatric Piptal with Phenobarbital slows down spasm, diminishes pain and crying, improves feeding patterns . . . permits sleep and rest . . . for patient and family.

Pleasant tasting Pediatric Piptal with Phenobarbital is miscible in milk, formulas and fruit juices, and may also be administered by dropper directly on the infant's tongue. Dosage is 0.5 cc. 15 minutes before feeding; in severe cases, 1.0 cc. four times daily. High doses may occasionally cause constipation with tenesmus and, rarely, flushing without fever. Contraindicated in bowel obstruction or sensitivity to phenobarbital or anticholinergics. Available in 30 cc. dropper bottles, droppers calibrated to deliver 0.5 cc.

PEDIATRIC PIPTAL® WITH PHENOBARBITAL

each cc. contains: 6 mg. phenobarbital (warning: may be habit forming); 4 mg. Piptal® (pipenzolate bromide), and 20% alcohol in a pleasant-tasting solution.

LAKESIDE LABORATORIES, INC.
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Prompt relief of pain and spasm in functional g.i. distress...



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1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. *8*:73-77 (Jan.) 1957
2—Asher, L.M.: Am. J. Digestive Diseases 4:272 (Apr.) 1959

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Report, Board of Censors and State Committee on Public Health–Midyear Conference November 18, 1965

By Dr. John M. Chenault

Mr. President, Members and Guests: It is my pleasure to report to you concerning some of the activities of your State Board of Censors, and its sub-committee on Public Health during the year 1965.

As you know, the Board of Censors, which is elected by the voting body of the Medical Association of the State of Alabama, is charged with a three-fold responsibility:

1. Attending to the affairs of the Medical Association itself.
2. Acting as the State Board of Medical Examiners.
3. Acting as the State Board of Health during the time when the Association is not in session.

The sub-committee on Public Health, composed of Paul Burleson, Hugh Gray and myself, has been directly concerned with many activities of the Health Department, and with the problems which have confronted it.

For example, in the late winter and early spring of 1965, there was an epidemic of a rather unusual type of influenza which caused the closing of schools in the Wilcox County area. Your Health Department expended many man hours in epidemiological work, and in assisting in isolating the particular viral strain, in co-operation with the viral disease research laboratories and facilities of the United States Public Health Service in Atlanta.

There were other problems which confronted the Department, such as those which followed the detonation of an atomic bomb in a salt dome in Mississippi. This caused a 6-inch sinking of a large land area which extended into Alabama. The effect of this radioactivity was expected to be reflected in contamination of ground water, and considerable time was spent and many tests done to assure that contamination had not occurred.

In North Alabama another problem of contamination resulted when some 6,000 gallons of a solution of potassium cyanide was carelessly spilled on the ground by metal industry workers. When half a dozen dead cattle and scores of dead birds were found at this small lake of potassium cyanide solution, the Health Department immediately became active and rendered invaluable advice in halting the spread of contamination.

There have been isolated epidemics of acute syphilis which have occurred in scattered areas over the state. These have been identified and treatment programs instituted by representatives of the State Health Department. However, the incidence of acute primary syphilis and other venereal disease is increasing, particularly among teenagers.

The Board of Censors was confronted with a problem concerning abuses in the sale of paregoric and cough syrups containing codeine. A hearing on these abuses was held early in 1965, at which time representatives of metropolitan police departments, sheriffs, and principals of negro high schools gave testimony that proved the excessive sale and

(Continued on Page 461)

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(Continued from Page 458)

abuse of paregoric and cough syrups containing codeine. Indeed the representatives from the schools stated that the teenage youths, after ingesting some of these cough syrups and small quantities of alcohol, would become euphoric, wild, and out of touch with reality. Police detectives testified that numerous robberies have been committed by people who were hopped up on this combination. Accordingly, regulations were adopted by the Board prohibiting the sale of paregoric or cough syrups containing one grain of codeine per ounce except by prescription, and these regulations became effective on November 11, 1965. It is hoped that this regulation will restrict the sale and prevent the abuse of the use of these agents, and thereby reduce crime in this state.

Two years ago the Board of Censors adopted a resolution stating that its primary effort for the 1965 Legislative session would be towards the goal of relieving the Health Department from its condition of financial chaos. It was noted that a large percentage of the key personnel of the State Health Department, and the various county health officers had become an aging population without replacement in sight. This was caused primarily by restrictive salary ceilings, and secondarily by inadequate funding of the Health Department at the state level. Conferences were held with our friends in both houses of the Legislature, especially with Speaker Albert Brewer and Mr. Rankin Fite in the House and Lt. Gov. James Allen in the Senate. These statesmen recognized the problems, and appreciated the great threat to the Health Department, and thereby to the health of the people of this state, and responded nobly. Mr. Brewer, as you remember, attended the mid-year meeting held here one year ago, and following that meeting spent several hours in conference with the Board of Censors and with members of the then newly-formed Board of Trustees. With the help of Messrs. Allen, Brewer, Fite, and many others the restrictive salary ceilings were removed with the enactment of HB 53, which in essence directs the State Committee of Public Health to set the salary of the health officer and of other employees of the state health department.

Our next problem was the amount of money which would be available for the operation of the state health department. We were grateful that the Governor included a $500,000 increase for the Health Department in his proposed budget, but felt that this was inadequate and elected to "go for broke" and try for the needed two million dollars. You will recall that at this time there was a prolonged filibuster in the Senate, and again relying heavily upon the advice of our friends in the Legislature, we enlisted the aid of the press, and persuaded interests which were friendly to the various other legislative groups, to introduce bills to propose a one-cent-tax on each pack of cigarettes. Since it was recognized that the institutions designed to treat the mentally ill in this state were also in financial need, the proceeds of this tax were divided with 60 per cent going to the Health Department, and 40 per cent to the Department of Mental Health. This division of funds gained considerable statewide support for the tax bill, which passed on the last day of the regular session. Collection of the tax began on October 1, 1965, and during the first month the proceeds received by the Health Department amounted to $153,000.

As I am sure you understand, all this required a great deal of time and energy, and could not have been accomplished without the wholehearted co-operation of the entire medical association. This was truly a team effort. Dr. Myers made speeches throughout the state generating enthusiasm and support for the bills. Mr. Patterson worked in our association office, charted the progress of the bills in the two houses, prepared press releases, and even found time to have a myocardial infarction. Conferences were held with legislative leaders and with the governor and various committees of the House and Senate. All members of the Board of Censors were active in these endeavors, especial-

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(Continued from Page 461)

ly Dr. Jones, Dr. Burleson and Dr. Gray.

The Association President, Legislative Chairman, and all members of the Board were present for the last legislative day—and night. Legislation, after all, is a compromise, and in the give and take of passing a bill, it is necessary that someone be present to speak for the Association—to amend, accept or reject proposals and to provide information and advice for our friends on the floor. But all these efforts would have been to no avail had it not been for the eyeball to eyeball contact which individual doctors had with their home legislators, pointing up a need and seeking help.

You will recall that in the 1963 session of the Legislature there was introduced a bill prepared by an Interim Committee on Mental Health. At that time medical association representatives strongly opposed this bill for two reasons:

(1) It provided for the organization of a Board charged with the responsibility of treating the mentally ill. This Board was to have been appointed by the Governor, subject to political domination, and composed of people of diverse interests, most of whom would have been totally unqualified in the management of illness.

(2) The bill, as proposed, would have made it possible to dissipate the physical resources of the mental institutions.

For these reasons the bill was opposed and defeated. However, because of many political ties and connections, and the interest of

(Continued on Page 464)

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(Continued from Page 462)

various members of the Legislature, a more acceptable compromise Mental Health bill was prepared, introduced, substituted, amended, re-amended, and finally enacted during the last hour of the last day of the 1965 regular session. This act expands the former Board of Trustees of the Alabama State Hospitals, taking their seven members, adding three members of the State Board of Censors, and three lay members from across the state being sure that each Congressional District has representation on the Board, and requiring that a majority of the Board members be doctors of medicine. The Board is given broad powers to do any or all things concerned with the diagnosis, treatment, rehabilitation and research into the causes of any or all forms of mental or emotional illness, including but not limited to psychoses, neuroses, alcoholism and mental retardation. Under this new system the Mental Health Board has supervision over the old division of Alcoholism, the Mental Hygiene Clinics formerly operated by the State Health Department, Bryce and Searcy Hospitals, Partlow School, and all other facilities for treatment of mental illness and retardation with instructions to do what is feasible and prudent in their operation.

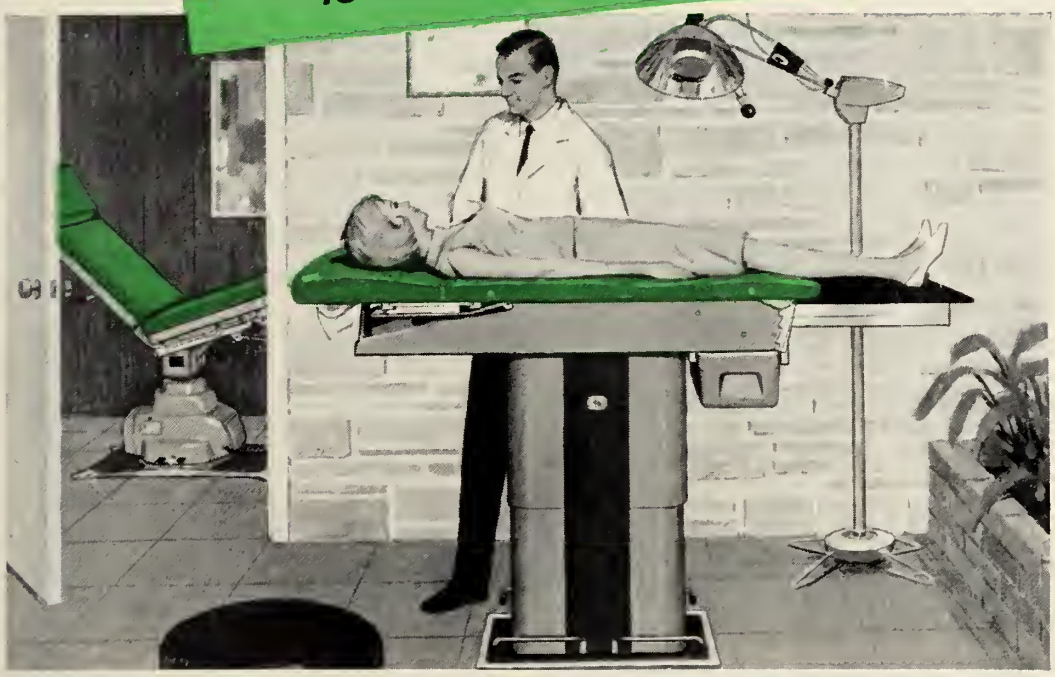
These are some of the highlights of the past year. With the increase in Health Department funds it is hoped that in the near future, two investigators will be employed to help control and prevent illicit traffic in drugs. Some 40 additional sanitariums are planned for the state. A division of accident prevention, employing photographers and investigators is contemplated. In the Mobile area a new shellfish laboratory will be built, for without it the entire shellfish industry stands in danger of losing its right to ship products in interstate commerce. Expansion of the work in the various county health departments is already under way. The State Branch Laboratories in Dothan and Selma have been reopened, and it is our hope that our State Health Department can provide more and better service to you, and play an ever increasing role in prevention of illness and promoting better health for the people of this state.



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HOSPITAL VISITORS--- PLEASING OR PERILOUS?

Hospital visitors who are laden with gifts, flowers, food, beverages, good-will and conversation for their hospitalized friends or relatives may be, in some instances, just the opposite of what the doctor ordered, according to an article in HOSPITALS, Journal of the American Hospital Association.

Visitors are highly important to many patients who need cheering-up, but they are the source of problems to both patients and hospitals, according to the article "Coping with Visitors: Police or Public Relations?" in the September issue of the journal.

Although there are no statistics on the number of hospital visitors, on the basis of one visitor a day for each hospitalized patient, a "modest estimate" is that the number of visitors each year exceeds by several million the total population of the United States, the American Hospital Association says.

With them, these visitors bring in addition to presents, germs, bacteria, and in a few cases, baskets loaded with food for a picnic on the hospital lawn.

"Hospitals have discovered there are perils to the patient from unregulated visiting as well as from no visiting at all," asserts an editorial relating to the article in the magazine.

Inconsiderate visitors who overcrowd patient rooms, who wander aimlessly through hospital corridors, who sit on beds, who bring food and beverages to patients on strict diets cause trouble, the journal article says. But hospital authorities see visitors as necessary.

"The adult patient returns to a feeling of dependency when he is ill," the article states. "He needs emotional support and a reminder of the world outside the hospital when he is convalescing. Like a soldier at a distant post who receives no mail, the patient with no visitors may look longingly at persons visiting other patients."

But unregulated and violated visiting rules and standards often result in patients complaining of too many visitors, infection control becoming difficult, and hospital personnel taxed beyond endurance, the staff-written report says. As a result, some hospitals swing to the opposite extreme and institute rigid visiting rules.

A number of examples of problems caused by visitors ignoring rules or manners are described in the article.

In one hospital, visitors entered through any of 35 doors in seven different buildings despite rules against indiscriminate wandering around the hospital. Another hospital liberalized its visiting hours to 6½ hours each day. In spite of this, visitors appeared as early as 7:30 a. m. and some stayed as late as 11 p. m.

It was the custom of farm families to drive to the grounds of a rural hospital following Sunday church services and unfold a picnic lunch. After lunch, the children remained outside to play on the hospital lawn while their parents went into the hospital to roam from room to room, looking for friends to whom they could pass a kind word.

In many instances, the visitors have been known to upset a patient by personal comments or by bringing him the latest news and gossip from home, some of it disquieting. Visitors may tell the patient that a neighbor "died from the same thing" or that the patient "looks awful."

The Ontario Hospital Association in Canada uses a series of cartoon posters in hospitals appealing to good sense and good humor in maintaining visiting rules. The theme: "Visits should be enjoyed—not endured."

"As hospitals steer a difficult course between being overzealous clockwatchers and overpermissive hosts, they are in the familiar position of being unable to please everybody, no matter what they do," the journal editorial adds.

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Phenylbutazone has not replaced physiotherapy, x-ray treatment, or local injections of hydrocortisone in the more chronic conditions, but it may advantageously be combined with these measures.

Contraindications
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage
Initially, give 400 mg. daily (one capsule q.i.d), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. Butazolidin alka contains antacids and an antispasmodic to minimize gastric upset.

Note: The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

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homatropine methylbromide	1.25 mg.

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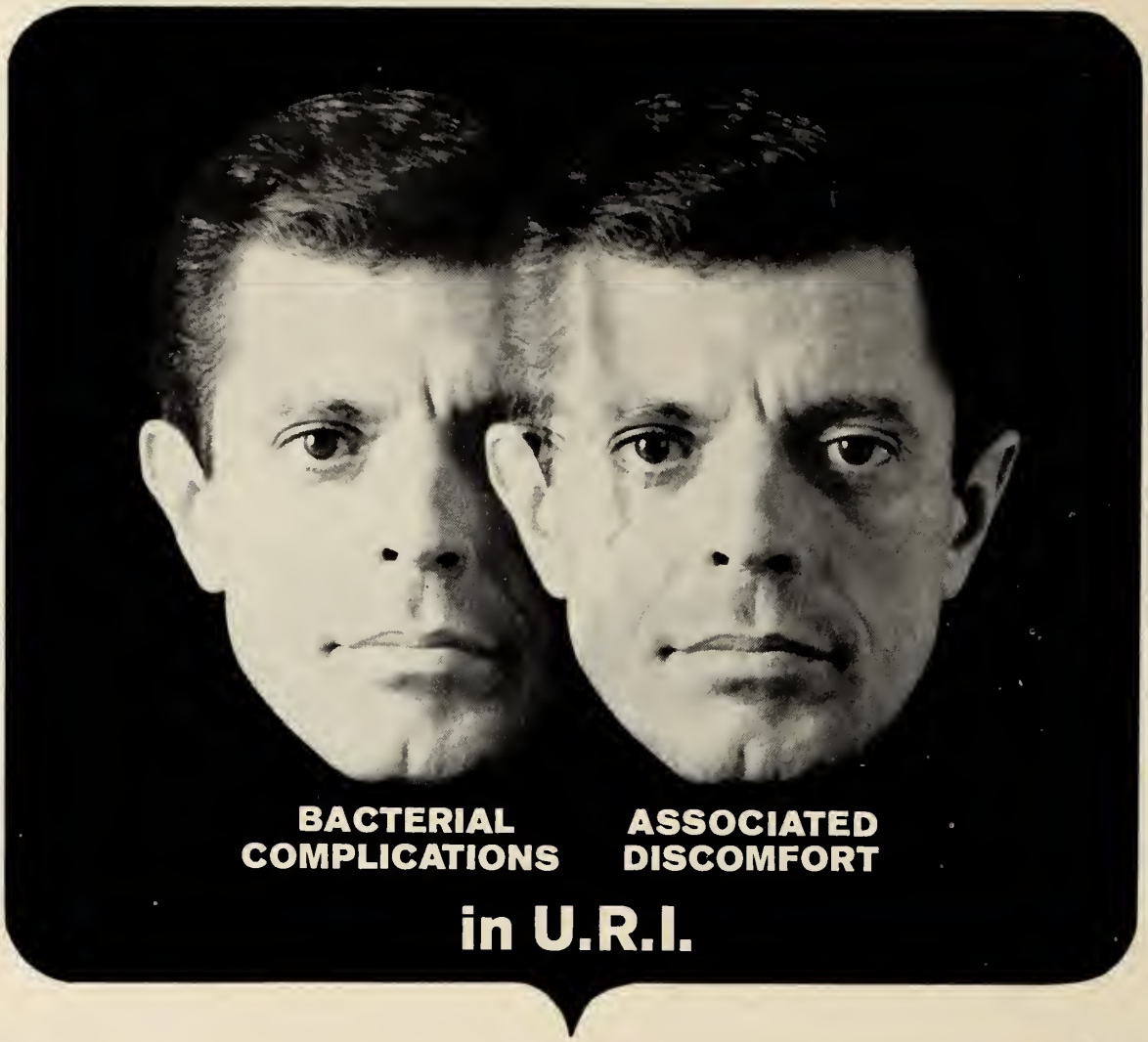
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Effective in controlling complicating tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects include drowsiness, slight gastric distress, anorexia, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation), photodynamic reaction to sunlight and increased intracranial pressure (in young infants). Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals. Patient should avoid direct exposure to artificial or natural sunlight; and should not drive a car or operate machinery while on drug. Reduce dosage in impaired renal function. Stop drug immediately at the first sign of adverse reaction.

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DR. E. B. CARMICHAEL HONORED BY CHEMISTS

Dr. Emmett Bryan Carmichael, editor of the *Alabama Journal of Medical Sciences* and Assistant Dean of the University of Alabama Medical College and School of Dentistry, is to receive the 1965 Southern Chemist Award for outstanding contributions in his field.

Dr. Carmichael will accept the gold medal and honorarium on December 3 at a banquet for the joint Southeast-Southwest Regional American Chemical Society meeting to be held in Memphis.

Dr. Harold Lyons, professor of chemistry at Southwestern University and Chairman of the Awards Commitee, wrote Dr. Carmichael he had been selected as the 16th recipient of the annual award "in recognition of your outstanding contributions to chemical and other scientific research and education in the South."

Southern Chemist, monthly journal of the American Chemical Society, is also a sponsor of this annual award.

Dr. Carmichael has been with the University of Alabama since 1927 and has been a professor since 1932. He became Assistant Dean of the Medical College and the School of Dentistry in December 1959. He headed the Department of Biochemistry both in Birmingham and on the Tuscaloosa campus until 1960. He came to Birmingham with the faculty group that helped expand the Medical College into a four-year school in 1945.

Dr. Carmichael holds B. A. and M. S. degrees from the University of Colorado and a Ph. D. degree from the University of Cincinnati. His first teaching assignment was that of instructor in the Department of Chemistry at the University of Colorado.

He also has written numerous articles in scholarly publications, is Chairman of the Gorgas Scholarship Foundation and was the Phi Beta Pi Man of the Year in 1954. He received the First Honor Scroll of the Alabama Chapter, American Institute of Chemists.

1966 Norman A. Welch, M. D. Essay Contest on Medical Ethics

The American Medical Association, through its Judicial Council, will sponsor a Medical Ethics Essay Contest, open during this academic year to junior and senior students in accredited medical schools in the United States.

The contest, to be known as the Norman A. Welch, M. D. Essay Contest, is another step in the Judicial Council's Expanded Program on Medical Ethics, according to the joint announcement of F. J. L. Blasingame, M. D., AMA's Executive Vice President, and James H. Berge, M. D., Chairman of the Judicial Council.

Cash prizes totaling $1,000, made possible by a special appropriation by the AMA's Board of Trustees, will be awarded to the winning essays. First prize will be $500, second prize $300, and third prize $200.

The contest is being named in honor of the late Norman A. Welch, M. D., a leading figure in American medicine for many years, who died September 3, 1964, while serving as the 118th President of the AMA.

Complete contest rules, as well as suggested essay topics, are available upon written request from the Department of Medical Ethics, American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610. They also may be obtained at the offices of the medical school deans.

June 1, 1966, has been set as the deadline for entries in the contest, which the Judicial Council hopes will be continued on an annual basis. Awards in the 1965-66 contest will be announced at the AMA Clinical Convention, in November, 1966.

Judging of the contest will be by a Medical Ethics Essay Contest Committee, composed of prominent physicians, and by members of the Judicial Council.

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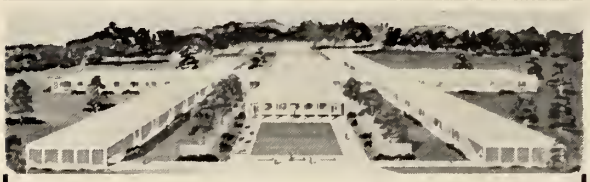
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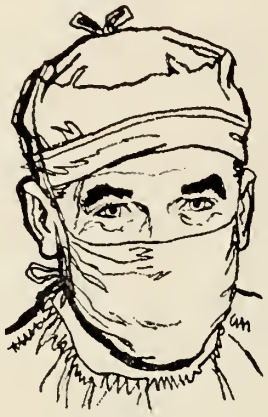
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Unfortunately, not all of us have the opportunity to participate actively in actual teaching; indeed, the pace of practice is often such as to make it nearly impossible to participate in formal learning, especially where travel to distant post-graduate courses and meetings is required. It is reassuring to note that the administration of the Medical College of Alabama recognizes its own obligation in providing superior continuing education programs.

Herein lies a very important "raison d'etre" of the Caduceus Club, for only through such an organization can many needs of medical education in our state be met. The financial requirements of continuing medical education and the upgrading of certain selected areas of the Medical College can only be met (and are being well met in other states) by such groups as the Caduceus Club, which provide additional support.

Membership in the Club is open to all high-minded citizens, but it is incumbent on the physicians of the state to make the laymen aware of medi-education's potential benefit to all of our people. The Caduceus Club can grow to such strength as to provide programs that would otherwise be virtually impossible. There is the particular need, mentioned above, in the field of continuing medical education—that is the bringing of newer knowledge and techniques to the individual practitioner, even in remote areas of Alabama.

In February, 1966, there will be a formal dinner meeting, a distinguished affair, to honor all Charter Members (those joining prior to the meeting date). These Charter Members will also be honored by a bronze plaque in the Medical College and each will receive a suitable "objet" for his office.

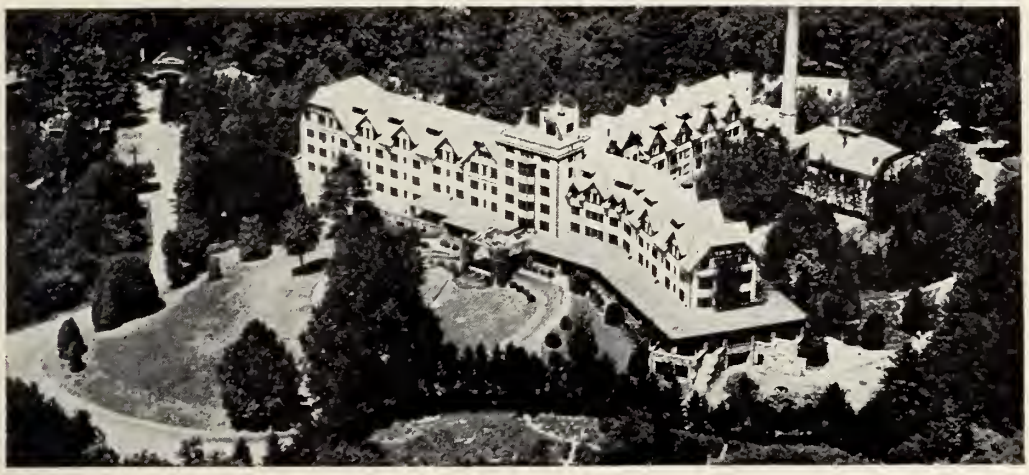
The minimum price of membership in this organization is $100 annually. Such a continuing commitment is indispensable to programs of merit. Most physicians are blessed sufficiently—and work sufficiently hard, it should certainly be added—so that their income tax bracket makes their actual net contribution significantly less than this amount, since it is tax exempt. In considering the amount of the dues, each physician should pause for a minute and consider just how valuable his own medical education is. This is not only to say actually in dollars and cents, but also to include the status and intrinsic worth one assumes by the very nature of this education.

If you are not contacted through your hospital staff or some organization within the near future, you should write Edwin Waldrop, M. D., Birmingham (Caduceus Club President), or the Caduceus Club office at the Medical College (Jimmy Beard, Executive Director) regarding **charter membership.** Physicians in other states are helping themselves and helping doctors-to-be in this tangible manner. Alabama's physicians must too.

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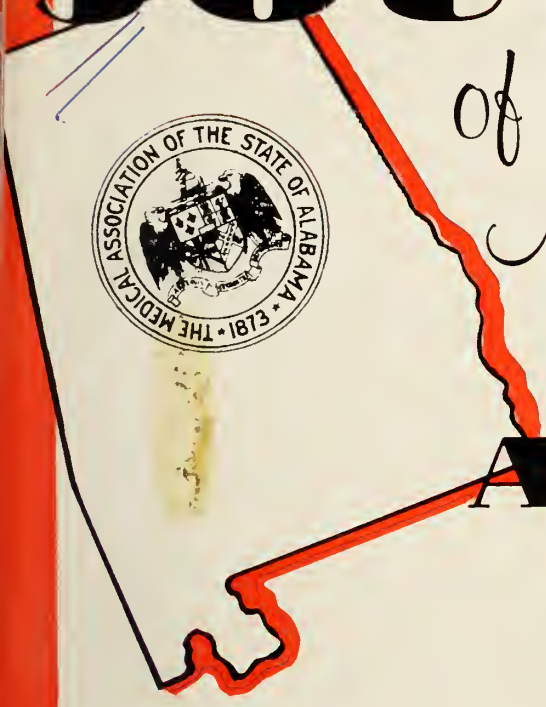
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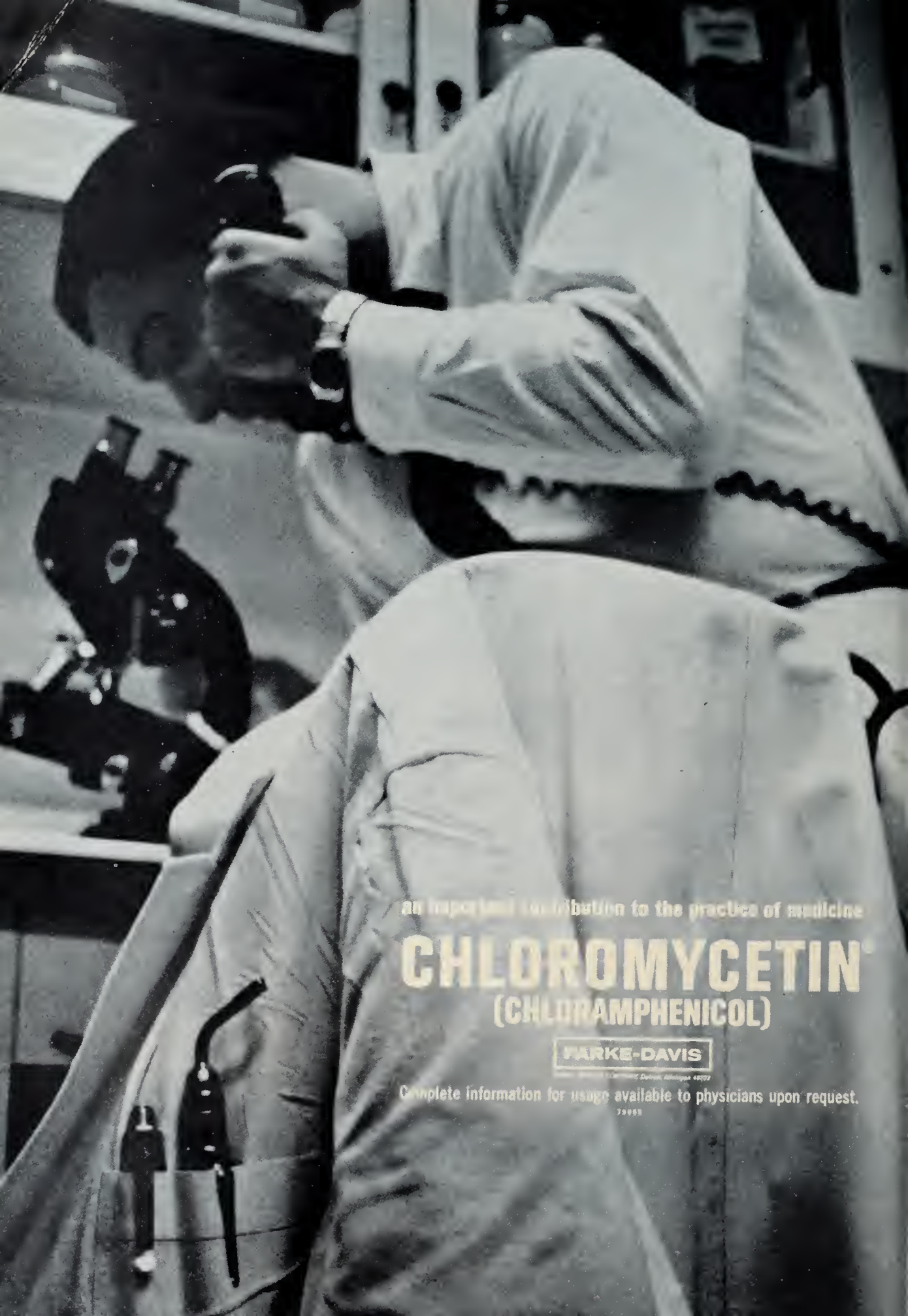
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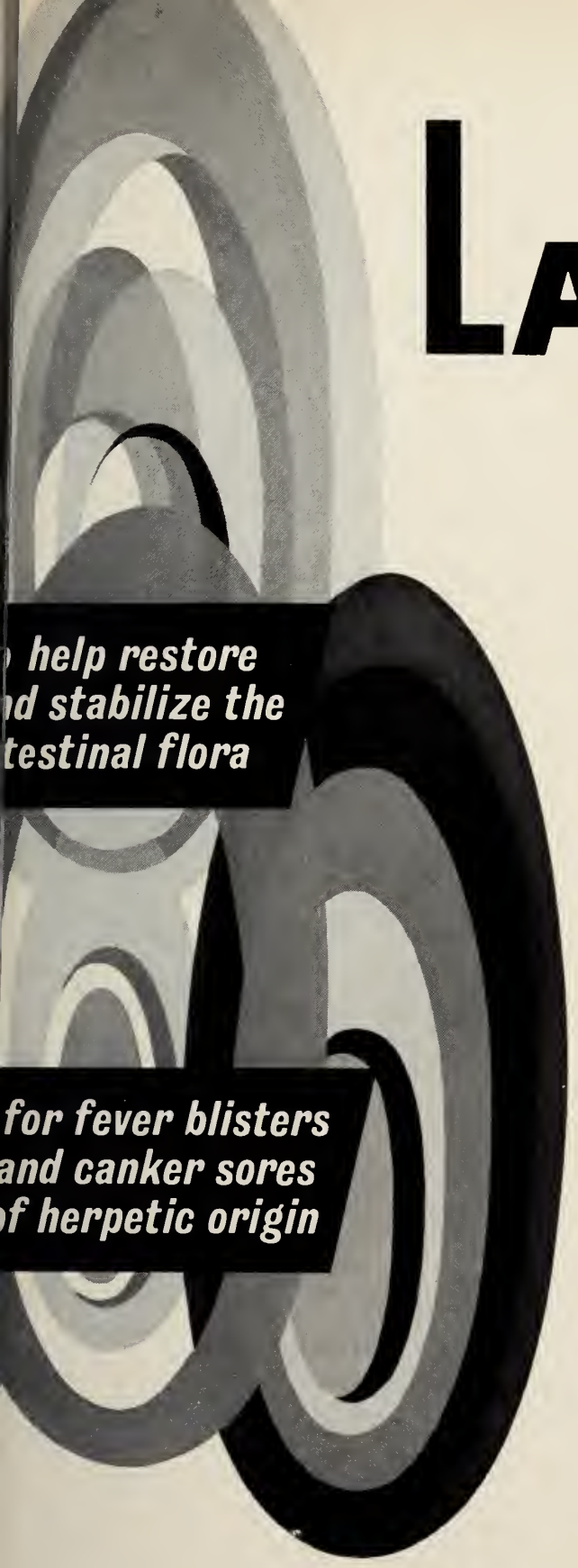
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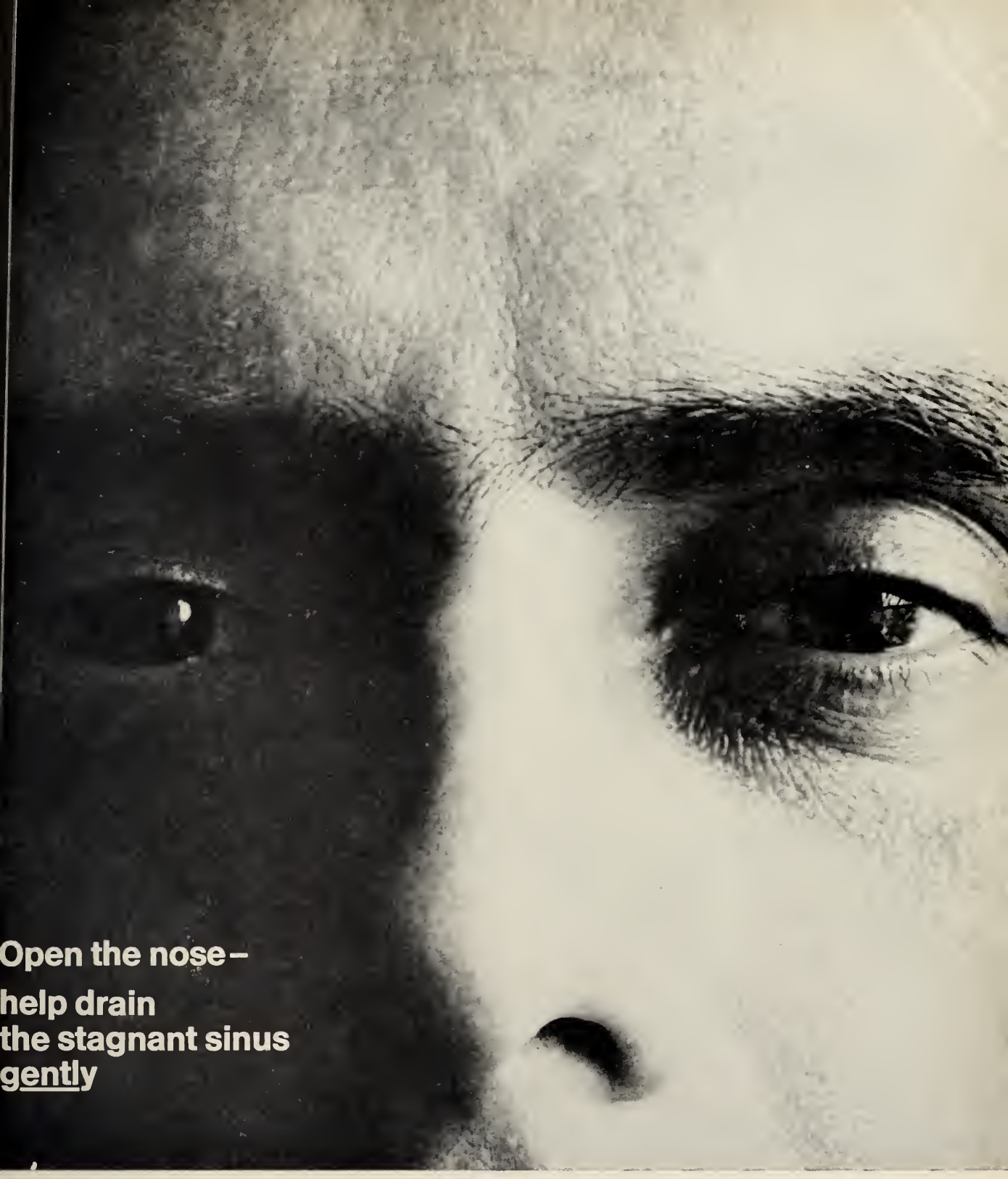
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*Proctor, D. F.: The Nose, Paranasal Sinuses, and Ears in Childhood, Springfield, Ill., Charles C Thomas, 1963, p. 34.

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For the individual patient with bacterial gastroenteritis encountered in private practice, these proven advantages of Furoxone are equally meaningful:

▪ exceptionally broad range—includes practically all bacterial species commonly implicated in gastroenteritis and diarrhea ▪ rapid, decisive bactericidal action ▪ minimal development of bacterial resistance—often effective against strains now resistant to antibiotics and sulfonamides ▪ well tolerated ▪ causes no major alteration of the normal intestinal flora ▪ does not encourage monilial or staphylococcal overgrowth

Indications: Effective in enteritis and diarrhea caused by most bacterial pathogens as well as Giardia lamblia. Side Effects: Are infrequent. Sensitization, in the form of vesicular or morbilliform rash, has occurred in a few patients but subsides promptly on cessation of treatment. Primaquine-sensitive patients may develop a mild reversible hemolytic anemia. Nausea, emesis, headache or malaise may occur occasionally. To obviate alcohol-disulfiram type reactions, advise against use of alcohol during therapy and four days thereafter. Do not give to infants under one month of age.

Composition: Furoxone Liquid contains, per 15 cc. tablespoonful, furazolidone 50 mg., pectin 225 mg., and kaolin 3.0 Gm. Furoxone Tablets each contain 100 mg. of furazolidone.

For round-the-clock medical consultation on any Eaton product, call the medical consultant on duty, person to person, Norwich, New York, Area Code 607, 334-9911.

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President's Page



The Medical Association of the State of Alabama is an association of component county medical societies. As such, the policies and actions of the State Association should reflect the wishes of the majority of the County Medical Societies at all times. This can be accomplished only if there is a sincere effort at two-way communication between the member societies and the Association.

The Midyear Conference for County Society Officers and Committee Chairmen in Montgomery on November 18, 1965 was a strong effort by the Officers, Boards, and central executive office of the State Association to communicate and share ideas with the representatives of the component societies. All major committees of the Association were asked to report on their present activities and recommendations. A report of AMA policies was given by one of our delegates, and the various AMA functions available to County Medical Societies were outlined in a movie by the AMA Field Representative.

The ALAPAC Committee presented a stimulating report and sponsored an address by Dr. Hoyt Gardner, a surgeon of Louisville, Kentucky, who is on the AMPAC Board. Of particular importance and interest was a report by the President-Elect, Dr. J. O. Finney, of a recent Orientation Conference on P. L. 89-97. As a luncheon speaker, we were fortunate to have Dr. Ed Annis, Past President of the AMA.

Opportunity was given after each report for questions and discussion from the County Society representatives present.

Unfortunately, there was disappointingly poor representation of the County Medical Societies at this Conference which had been planned specifically for them. Excluding program participants and members of Boards of the State Association, there were only 34 members of MASA registered, and these represented only 14 County Medical Societies. This dismal result was achieved in spite of at least two months of advance publicity, special letters of invitation to each County Medical Society and to each individual Society officer, and repeated announcement and invitation in the *Alabama M. D.*

The beginning of 1966 affords an opportunity for all Officers and Boards of the Association and all officers and members of Component County Medical Societies to resolve to work toward a mutually dependent relationship of free exchange of ideas and communication of objectives and accomplishments. In this way, the State Association can always reflect the policies of a majority of its County Societies. This can only be done if

(Continued on Page 484)



The Pain Is Gone

Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

'Empirin'® Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

Keeps the Promise of Pain Relief

BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.

(Continued from Page 482)

the County Society leaders are willing to keep informed of state and national developments at all times.

The objectives expressed in this article are so important that the following efforts on the part of the Medical Association of the State of Alabama are already being made:

1. Publication of timely articles in the weekly *M. D.* and monthly *Journal* of the Medical Association of the State of Alabama.
2. Special mailings to County Societies and members of any important developments.
3. Sponsor the Midyear Conference for County Society Officers and Committee Chairmen with the hope that this will develop into the most important forum of the year for exchange of ideas and information between the Association and County Societies.
4. Request each County Medical Society to have its own committee corresponding to each major committee of MASA with suggestions at County Society level being passed to the appropriate MASA committee for consideration as Association policy.
5. Availability of central office staff (Executive Secretary or Assistant Executive Secretary) to go to County Medical Society meetings on request to discuss Association policies, accomplishments, and plans.
6. Availability of AMA Field Representative to go to County Medical Society meetings on request.
7. Effort by Officers of MASA to attend County Medical Society meetings if invited to do so within the limit of available time.

It is to be hoped that the leaders of each County Medical Society will exert every effort necessary to bring about full identification and contribution of his Society in the total effort of **our** Association.

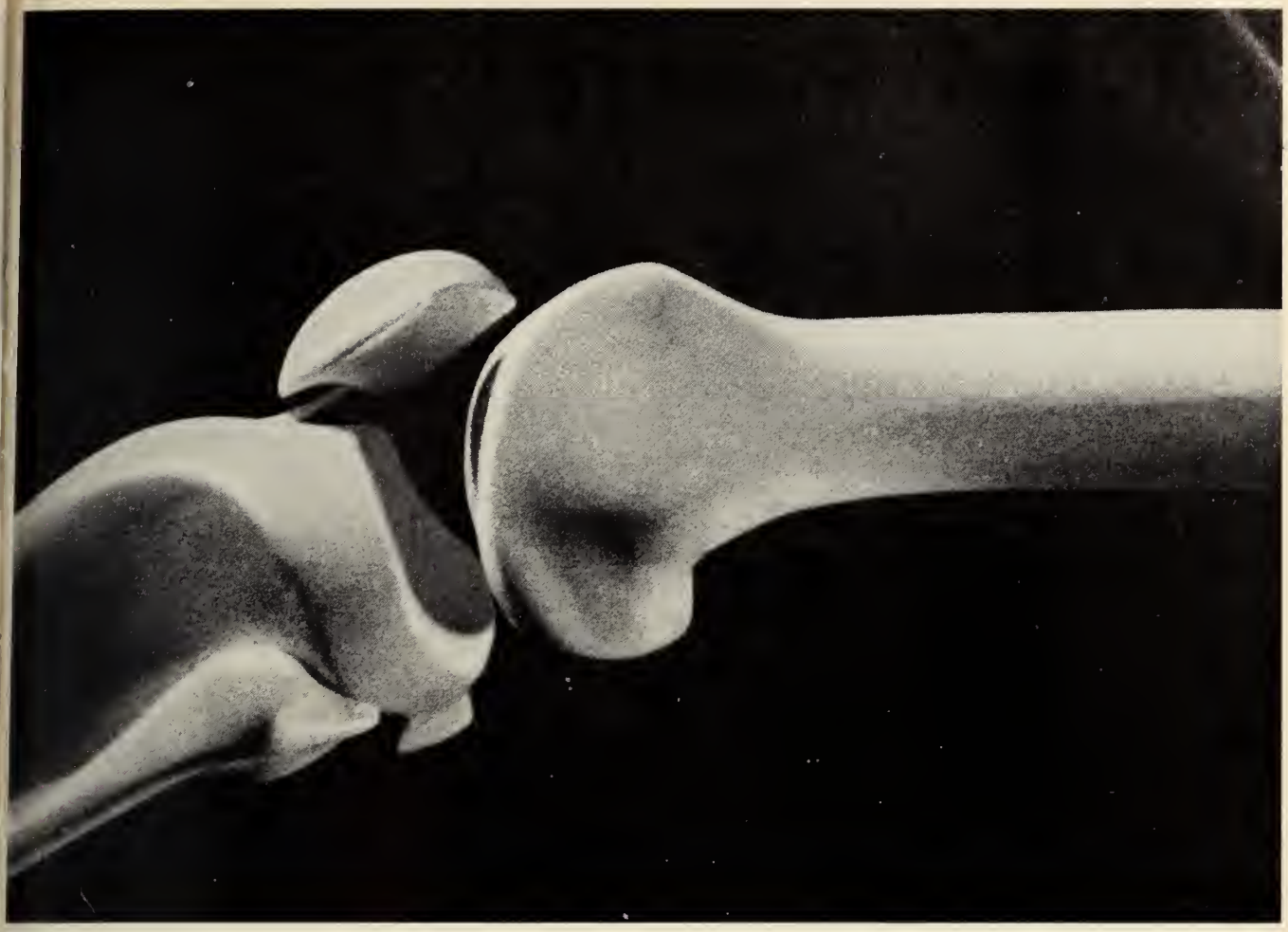
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President

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dried aluminum hydroxide gel	100 mg.
magnesium trisilicate	150 mg.
homatropine methylbromide	1.25 mg.

Usually works within 3 to 4 days in osteoarthritis

The trial period need not exceed 1 week. In contrast, the recommended trial period for indomethacin is *at least 1 month.*

That's why it's logical to start therapy with Butazolidin alka—you'll know quickly whether or not it works. And usually, it will.

A large number of investigators have reported major improvement in about 75% of cases. Some patients have gone into remission. Relief of stiffness and pain may be followed quickly by improved function and resolution of other signs of inflammation. And Butazolidin alka is well tolerated, especially since it contains antacids and an antispasmodic to minimize gastric upset.

Contraindications
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile, or when other potent drugs are given concurrently. Large doses are contraindicated in patients with glaucoma.

Precautions
Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Make regular blood counts. Use greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy.

Adverse Reactions
The most common are nausea, edema and drug rash. Hemodilution may cause moderate fall in red cell count. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Dosage
The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

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The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—The Public Health Service has expanded its "pap" test program with a goal of providing cervical cancer tests for most women who enter hospitals and many of those who see physicians for any reason.

A total of $6 million has been allotted for the expanded nationwide campaign.

Grants will be made to hospitals, medical schools, state and local health departments and non-government health groups for training of technicians, post-residency training of physicians, purchase of laboratory equipment, examination of hospital outpatients and other such expenditures.

Since last March, the American Academy of General Practice has been implementing for the PHS an office cancer detection program. A PHS spokesman termed the program "most effective," although not costly.

The PHS said it expects to achieve its goal in hospital tests within the next five years, with the number of hospitals providing this service to all adult women patients increasing each year during this period.

Hospitals providing care for the poor and medically indigent will receive first consideration in the awarding of grants. These patients have not been tested usually for cervical cancer, the PHS said. PHS Surgeon General William H. Stewart said the new hospital-based screening program reaching high-risk, low-socio-economic groups offered "a truly effective" means of fighting cancer through the "pap" test for early detection.

Although the "pap" test was developed more than 20 years ago, only 20 per cent of the nation's 62 million adult women had received the test last year, the PHS said.

The report of the President's Commission on Heart Disease, Cancer, and Stroke proposed a national cervical-cancer detection program as the next logical step to expand the limited program previously carried out by the PHS' Cancer Control Program. The clinical training programs for cancer control will have $6 million in funds for the next 12 months, double the amount previously available. The grant-aided programs will be carried out by medical schools, hospitals, and such health groups as the American Cancer Society, the American Academy of General Practice, and state and local health departments.

After President Johnson named the National Advisory Council on Regional Medical Programs to advise the government on programs authorized by the Heart Disease, Cancer and Stroke law, Dr. James Z. Appel, AMA President, expressed regret that "the AMA was not asked to submit any nominations to this important body."

"Frankly, we are disturbed that the PHS has taken this action in view of our known interest in this Act and the inclusion before its enactment of the 20 amendments we had proposed," Appel said. "You may remember that one of the amendments incorporated into the final bill was our suggestion that the Advisory Council have final authority in approving or disapproving grant requests rather than only advisory authority as initially provided."

Nonetheless, Appel told the AMA House of Delegates in Philadelphia:

"If we provide effective leadership, and if the PHS cooperates, it may be that this law will permit the development of programs which will benefit the public and be acceptable to the profession. I cannot urge you strongly enough, therefore, to take steps now through appropriate state and local society committees to meet with medical school deans, state health department directors, teaching hospital administrators, and department heads in an effort to establish jointly a series of programs under the Act that would be wholly beneficial."

Named to the Advisory Council:

Dr. Michael E. DeBakey, Houston, who headed the commission that recommended the program; Dr. John Willis Hurst, Atlanta, the President's heart specialist; Dr. George E. Moore, Buffalo, N. Y.; Dr. Clark M. Millikan, Mayo Clinic, Rochester, Minn.; Dr. Cornelius M. Traeger, New York, N. Y.; Dr. Leonidas H. Better, Chicago; Mary I. Bunting, President of Radcliffe College; Gordon Cumming, Sacramento, Calif.; Dr. Bruce Everist, Ruston, La.; Dr. William Peeples, Maryland Health Commissioner; Dr. Robert J. Slater, Burlington, Vt.; and Dr. James T. Howell, Detroit.

Surgeon General Stewart will be chairman.

* * *

Clinical testing of the experimental drug DMSO has been discontinued by voluntary agreement of the drug sponsors and the Food and Drug Administration. The action was prompted by reports of adverse effects on the eyes of laboratory animals. About 1,000 investigators had been testing the drug on thousands of human patients. Both the American Medical Association and FDA previously had warned that attempted self-medication with the material was dangerous.

DMSO is produced as an industrial solvent as well as grades for medical research purposes.

A special advisory committee on non-government medical experts is conducting a comprehensive review of side-effects of birth control pills.

The Advisory Committee on Obstetrics and Gynecology was appointed in November by the Food and Drug Administration because of reports that women who had taken oral contraceptive pills had suffered thromboembolic phenomena including strokes, thrombophlebitis and pulmonary embolism, and various eye and vision manifestations. An article in the AMA's Archives of Ophthalmology reported 69 cases of eye ailments, migraine and strokes among women who had taken the pills.

As an interim measure, the FDA directed manufacturers of the pills to put on package labels two warnings—1) use should be stopped if eye problems occur, and 2) women who have had strokes should not take them.

It is estimated that more than four million American women have been taking birth control pills which are manufactured by seven U. S. drug firms.

At its first meeting the seven members of the special committee—all medical school gynecologists and obstetricians—concluded that there was no immediate need for immediate action on the reports of adverse experience with oral contraceptive pills. The committee believed that "final recommendations . . . can safely await the conclusion of its deliberations."

Two more Committee meetings were scheduled, in January and March. Dr. Joseph F. Sadusk, Jr., FDA Medical Director, said the Committee probably would issue its final report following the March meeting.

The FDA put on computer tape and turned over to the Committee for evaluation all of the clinical reports it had received on suspected adverse reactions from oral contraceptive drugs. The FDA pointed out that it had "emphasized previously that these are natur-

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Editorial COMMENT

A Fervent Wish For The New Year

The dawn of a new year prompts the Editor and staff of the Journal of the Medical Association of the State of Alabama to wish all our readers happiness and success in the months ahead.

Here at 19 South Jackson Street we have taken advantage of the occasion to reflect upon our performance of the past twelve months. It is our fondest hope that we have learned from our mistakes and that, in the year ahead, our labors will be reflected in a more informative and interesting publication.

We hope that 1966 will bring us the wisdom to serve our readers to their ultimate expectations, and the energy to achieve our own dreams for the betterment of this Journal.

To all of you our fervent prayer for you and those you love is:

Joy, and Peace!

Wm. L. Smith, M. D., *Editor*
L. P. Patterson, *Mng. Editor*
Mary Nell Williford, *Asst. Mng. Editor*



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.





United Action Is Essential To Success

On another page in this issue, Dr. James G. Donald, President of the Medical Association of the State of Alabama, diagrams a blueprint for County Medical Societies wherein energies expended at the local level can be reflected in a stronger and more influential State Association.

More basically, leadership in the County Societies have a responsibility to marshal their membership to the extent that every physician in Alabama personally feels an obligation to the profession of Medicine beyond the limited horizons of County activities.

It is a grievous thing for any organization to fragmentize themselves on issues of transitory importance when the exigencies of the times demand the strongest unity of purpose and action.

When any profession becomes divided, their adversaries can attack them singly and devour them one by one. A battlefield strategist wants no better advantage than to divide his foe and defeat him in detail. Robert E. Lee prolonged a hopeless war for five long years by using these very tactics.

It is well and proper that specialists should organize and labor for scientific advancement. It is foolhardy and dangerous for these same men to speak independently on matters involving the commonweal.

Let us take public relations, as an example. Here is a newly-developed science which can, expertly organized and operated, have a profound effect on Medicine's image. This is an activity which demands diligent planning and careful activation. Timing and phraseology are of the first essence if maximum results are to be achieved.

A dozen medical organizations speaking in as many squeaky voices amounts to unintelligible cacaphony. Statements which differ one from the other result in confusion and a multiplicity of interpretations. No public relations program is to be preferred to a dozen different ones, even though the same overall objective is sought.

In unity alone is there maximum strength and in such difficult and delicate fields as public relations, sponsorship of legislation and political activities the victory most often goes to those who can speak with the most commanding voice.

"Sound, Simple Clinical Observation . . ."

I maintain that an experienced observer can tell whether a drug puts a patient to sleep, relieves pain, stops a cough, relieves an itch, lifts a depression or improves motility in arthritis without placebos and double-blind controls. Reciprocally, I have seen smart, young, relatively inexperienced investigators completely miss the obvious with their sophisticated technology. There is a place for sound, simple, clinical observation and I hope general practitioners will insist on having their data considered along with the other. I have an idea that they will be right as often as their younger, instrumented, double-blind brethren. Theodore G. Klumpp, M. D., in *GP,* November 1965.

Guest Editorial....

This article, reprinted from the Montgomery Advertiser-Journal, *is one in a series entitled "Career Profiles." The article is intended for young people, but it was thought that physicians in Alabama would find it interesting and informative. For information about the new Medical Scholarship Program write to the Committee on Legislation, Medical Association of the State of Alabama, 19 South Jackson Street, Montgomery, Alabama or to the office of the Dean, Medical College of Alabama, 1919 7th Avenue South, Birmingham, Alabama.*

Demands Of Medical Training Challenge Student

By S. J. Selikoff, M. D.

The practice of medicine as a profession has much to offer but also demands a great deal. Let us first consider the demands.

A young person considering medicine as a career should be well in the upper half of his or her class. A good, receptive and retentive mind is needed to accumulate the vast amount of knowledge that has been unfolded for us by scientists in the medical and related fields.

The only way the admissions committee of a medical school can judge a prospective student is by grades obtained in premedical studies. There are comprehensive examinations and aptitude tests, but these too are related to a student's excellence in classwork.

The study of medicine demands much time. Three or four years of college are followed by four years of medical school and a minimum of one year's internship.

For most doctors this is still not enough, and an additional four to five years of residency training are required to turn out a specialist.

The material rewards during this long learning period are not great and determination and dedication are prime requisites at this time. Nor does completion of this phase automatically guarantee immediately a life of leisure and luxury.

True, many positions may be open in institutional fields, teaching and research.

But for the majority going out in private practice, there is another beginning to be made with an uphill climb for recognition and security.

The hours are long, responsibility great and disappointments are many. In addition to this, the private practice of medicine faces a questionable future in regards to possible government control as in some other countries.

Why then do so many students apply to medical schools each year?

Well, let us now discuss what medicine has to offer. The practice of medicine, including of course teaching and research, is a challenge that captures the imagination of the student, the scholar.

It is like a never ending game of chess, with disease as the adversary. Eventually we lose, since death comes to all men. But we do win skirmishes, battles, and even campaigns. We extend the human life span, we save the young from premature extinction, we ease pain and allow man to walk straighter.

Do not think that the physician goes about like a knight in shining armor, tilting at the dragons of disease and thinking noble thoughts, because he does not. But the sum total of his services, from the relief of a bad cold to a dramatic organ transplant fits the above generalizations. There is also room in

(Continued on Page 494)



An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

Miltown® (meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

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# OF CULTURES	YEAR	% EFFECTIVE
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5,440	1963	88.0%
10,384	1964	88.5%

β-Hemolytic Streptococci [2,3,1]

2,448	1962	89.5%
1,519	1963	95.2%
2,492	1964	96.7%

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DEMANDS OF MEDICAL TRAINING

(Continued from Page 491)

the medical profession for the individualist, the man who wishes to be independent and original.

We are an expanding nation in terms of population and we will need more and more physicians, in practice, teaching in our schools and doing research in our laboratories.

We need bright young men and women to fill the ranks of the profession.

Those of you who qualify and persist will be rewarded with a sense of accomplishment hard to match in any other field. If you have a desire to study medicine, do so in spite of any discouragement or difficulty. It will be well worth your while.

Disability Under Social Security:

TOTAL-TEMPORARY IMPAIRMENTS NOW ENTITLED TO BENEFITS

George C. Risman, Ph.D., M.D.

Birmingham, Alabama

The recent 89th Congress passed 950 health bills, many of which will especially affect physicians. Of particular interest to this Agency and to Alabama doctors is the change in the medical criterion by which disability benefits under Social Security before the age of 65 are granted. As a result of this revision, disability-benefits can be awarded both for a temporary-total impairment as well as for a permanent-total impairment.

The Alabama Disability Determination Unit is a part of the Vocational Rehabilitation Service. Consisting of six part-time physicians and nineteen counselors trained in rehabilitation, its sole responsibility is the adjudication of claims for disability benefits. Unlike the Rehabilitation Service, it does not provide physician's services, medical care, or hospital benefits except as may be required to evaluate the alleged severity of an impairment. It processes about fifteen thousand applications annually from citizens who feel, or who have been informed by their physicians, that they are unable to work. All decisions of the Agency must be approved by the Bureau of Disability Insurance (Department of Health, Education and Welfare) before a claim is allowed or denied.

Prior to September 1, 1965, the Law regarding disability stated that benefits could be awarded only if "the medical impairment could be expected to result in death or **be of long continued and indefinite duration".** The term, long-continued and indefinite, was not defined legally and various interpretations resulted. This criterion has now been revised to read "a medical impairment expected to result in death or **which has lasted or can be expected to last for a continuous period of not less than twelve months".** Although the duration of an impairment has been revised, there has been no change in the definition of its severity[1]. Severity is defined as an "inability to engage in any substantial, gainful activity because of a medically determinable physical or mental impairment".

In essence, the application of the law has been simplified and the award of benefits liberalized. Hereafter, an individual with any impairment, the severity of which would preclude work for more than 12 months, will be entitled to monthly benefits. Examples

Dr. Risman practices internal medicine in Birmingham, and is (part-time) Chief Medical Consultant for the Alabama Disability Determination Unit.

[1]Refer to the detailed descriptions of disease syndromes in Title 20: Code of Federal Regulations; Section 404.1501 et seq.

(Continued on Page 500)





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rescribe improved belladonna therapy with more potent and





longer sustained effect than most synthetic antispasmodics..



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PRECAUTIONS: Frequent or continued use should be carefully supervised. Discontinue or reduce dosage if dryness of the mouth, rapid pulse, or blurring of vision occurs. Hytrona is contraindicated in glaucoma. Use cautiously in elderly people, especially when urinary retention is present. Phenobarbital may be habit forming.

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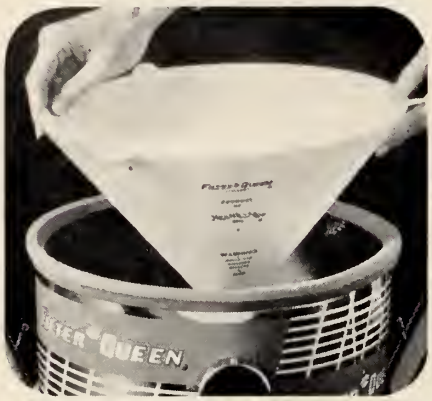


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2 Now unfold a clean white handkerchief and drop it into the Sanitary Filter Cone. (Even the daintiest, sheerest handkerchief may be used with perfect safety.) Then replace the turret top on the container.



3 Now turn the machine over to any one witnessing the demonstration, and have her start the machine and apply the nozzle to any place where there is obvious dirt and dust. Keep the machine operating for a full minute.

See the proof with the
FILTER QUEEN
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4 Remove the top of the container, and lift out the handkerchief. You'll find it spotless as it was when it went in! (Where did the dirt go? Look in the bottom of the container.)



DUST AS NO "VACUUM CLEANER" CAN!

Revolutionary...and in a class by itself!

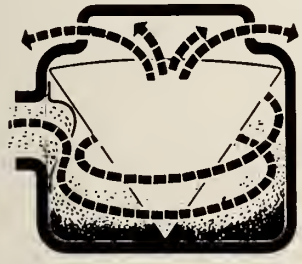
FILTER QUEEN

has the scientific cleaning features that hospitals need most

All "vacuum" cleaners were much the same until the FILTER QUEEN SANITATION SYSTEM was designed. FILTER QUEEN'S patented Sanitary Filter Cone eliminates the need for messy bags, traps practically all airborne contaminants passing into the machine (Harvard Medical School Report in Journal of the American Medical Association, November 25, 1958).*

Experienced hospital housekeepers know this well. That is why FILTER QUEENS have replaced every type of vacuum cleaner in hundreds of hospitals throughout the world.

FILTER QUEEN has no porous bag that permits dust and dirt to reenter the room. FILTER QUEEN operates on an entirely different principle, "Cyclonic Cleaning Action." Here's how it works: Inrushing air, laden with dirt and dust, is deflected by a patented inlet guide as it enters the



container; then is whirled by centrifugal force away from the cone. Dust and dirt are dropped to the bottom of the container. (See illustration.) Air, being lighter, is funnelled to the center of the "cyclone," filters through the Sanitary Filter Cone and returns to the room dust-free.

Why not ask your local FILTER QUEEN Distributor to make the dramatic handkerchief test (pictured at left) in your hospital? There is no better way to prove the improvement in cleaning ability between a FILTER QUEEN SANITATION SYSTEM and any type of vacuum cleaner. (You'll find your distributor listed in the Yellow Pages; or write Health-Mor, Inc. direct).

**We will be glad to send you a reprint of this report on request.*

What hospital administrators say about FILTER QUEEN

"I heartily recommend to any hospital administrator who is presently unhappy with the type of cleaning machine in use, that he try FILTER QUEEN for only two days and the machine will sell itself."

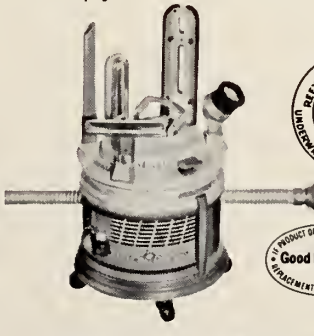
"The FILTER QUEEN is great—a very important factor in patient areas, and is constructed so as to prevent air turbulence of dust at floor level. Filtering of the air, while in general operation, is also a very important and desirable factor."

"One of the most pleasing features of the machine is its quietness. We can even clean in the rooms while occupied by the patients, and many have commented on how pleasant it is not to be disturbed by noisy, old-fashioned vacuum cleaners anymore."

"The air exhaust at the top of the unit is a wonderful feature, and the Sanitary Filter Cone is certainly our answer for working in closely confined patient areas."

"We thought we had a clean hospital and a fairly good method of achieving acceptable sanitation, but this little machine made us revise our thinking and our methods."

"A quiet motor which possesses excellent cleaning power and the convenience of having to clean out the cleaning compartment only once a month, has proved very advantageous. One of the most important points . . . is that there is no bag to empty."



FILTER QUEEN

In Canada: Filter Queen Corp., Ltd., 252 Victoria Street, Toronto, Ont. • **In Mexico:** Industrias Filter Queen, S.A., Av. Jardin #330, Col. del Gas, Mexico 15, D.F.

A Product of HEALTH-MOR, INCORPORATED, 203 North Wabash Avenue, Chicago, Illinois 60601

TOTAL-TEMPORARY IMPAIRMENTS

(Continued from Page 494)

might include un-united fractures of the long bones of the lower extremities; spinal fusions; practically all cerebral thromboses with significant neurological sequelae; well-established mental illness with an ill-defined prognosis; most cases of moderately-advanced and far-advanced tuberculosis, etc. Although the ultimate prognosis for complete recovery from each of these impairments is excellent, the duration usually exceeds twelve months. Since these examples satisfy the criterion of severity, and since the prognosis exceeds 12 months, entitlement to benefits would usually be established. The present practice is to cease these benefits when medical recovery has occurred or after an applicant's successful return to work.

On the other hand, when the impairment is not "severe," its duration is immaterial to the adjudication. Such examples might include hypertension without end-organ defects; post-operative status of herniated disc without neurological sequelae; incontinence, mild, following prostatectomy; mastectomies secondary to breast carcinoma; osteoarthritis without significant functional restrictions; myocardial infarction without significant sequelae, etc. In all of these instances, the impairment demonstrates prolonged duration —but the ability to engage in some type of substantial, gainful activity is not prevented.

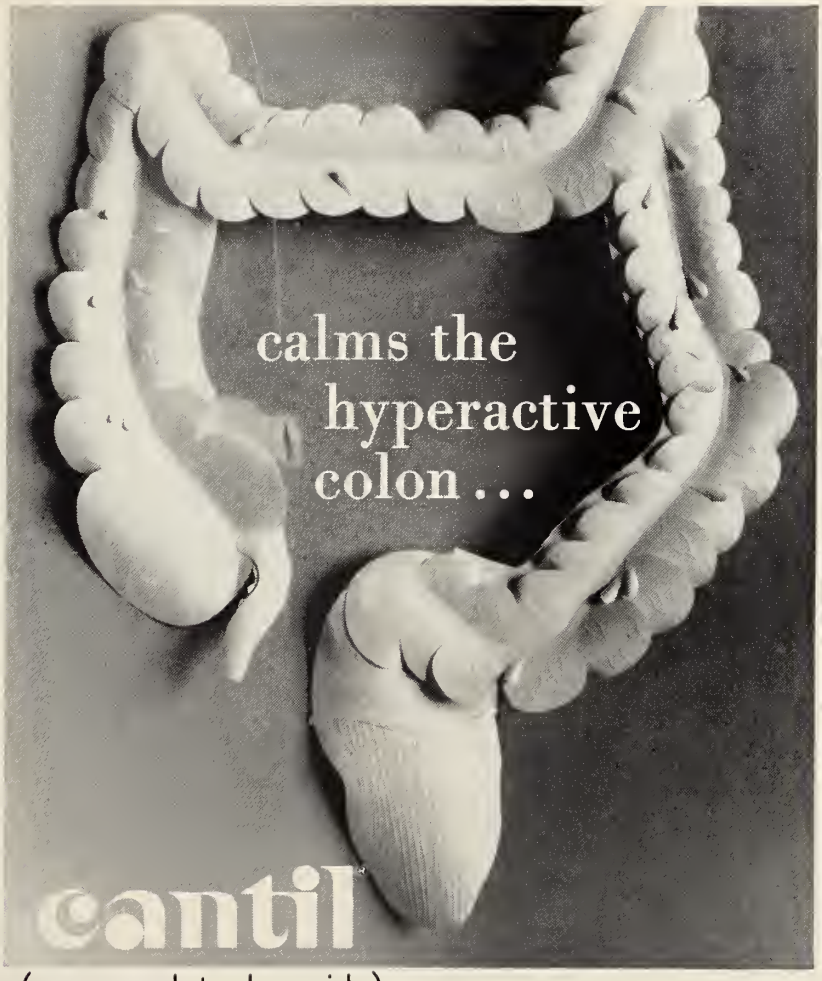
It appears to be the intent of Congress to provide financial benefits to those individuals who are **temporarily and totally impaired** as well as to those who have a **permanent-total** impairment. Unlike other insurance programs (commercial, Workmen's Compensation), there is no compensation for partial-permanent disabilities. All impairments are evaluated on the basis of their respective (1) severity and (2) anticipated duration. The final adjudication is frequently made more difficult by the (legal) necessity of making it not later than the sixth month of the illness.

It might be pertinent at this point to explain why physicians are not paid for supplying the initial medical data nor for providing ancillary information. This Agency, in conjunction with the Committee on Insurance (M. A. S. A.), has attempted unsuccessfully to persuade the Bureau of Disability Insurance of the advisability and feasibility of paying for this information. The Law specifically states that the applicant should be responsible for initiating the application and for providing the initial information — except under extenuating circumstances. The Bureau has apparently felt that its payment for initial information would be inconsistent with the Law and might absolve the claimants of their responsibility[2]. Although reimbursement cannot be made for these data, the cooperation of all physicians is nevertheless sought if the profession and the State Agency are to maintain this program on a sound medical basis.

Information supplied by the attending physician has always played an important part in these adjudications. His findings and opinions will now play an even greater role, since the 1965 amendments place as much emphasis on the intermediate progress as on the ultimate prognosis. If equitable and uniform decisions are to be made, closer liaison with the attending physician must be accomplished. Objective evaluations and complete reporting of medical observations will provided maximum information for the State Agency's decision and will minimize the need to contact physicians by letter or telephone.

Conclusions: The disability program of Social Security has hithertofore provided financial benefits only to individuals with permanent-total impairments. Following recent revisions, benefits can now be provided to individuals with temporary-total impairments which exceed twelve months in duration. Regardless of the duration, all impairments must still meet the stringent criterion of "severity".

[2]These comments are not **official** and represent only personal conclusions of the author.



(mepenzolate bromide)

helps restore normal motility and tone

Cantil (mepenzolate bromide) works in the colon. In irritable colon, spastic colon, ulcerative colitis and other functional and organic colonic disorders, it acts to:

- control diarrhea/constipation
- relieve spasm, cramping, bloating
- make patients more comfortable

with little effect on stomach, bladder or other viscera.

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects. Blurring of vision or dryness of the mouth were occasionally seen and were usually managed with a reduction in dosage. Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250.

CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201



CENSORSHIP RIGHTS

By Hon. Thomas M. Pelly

Washington, D. C.

Reports are being circulated around Washingtcn that the Federal Government is preparing a campaign to rewrite the history bocks used in our educational system.

This is, without a doubt, one of the most appalling disclosures that I have heard during my tenure in the House of Representatives.

It is my understanding that the drive to rewrite the textbooks is under the auspices of the Community Relations Service, an agency created by the 1964 Civil Rights Act to help mediate racial disputes.

It is the feeling within this agency that the history books do not give fair treatment to the Negro.

This may or may not be true; but the issue involved here is not one of civil rights, it is one of censorship rights.

I do not vacate my position of equal justice for all Americans, having always supported civil rights legislation, and certainly the goal of giving the Negro his rightful place in history books is commendable.

Again I say, the real issue is not one of civil rights but one of censorship rights.

In cther words, should the responsibility of writing, or rewriting, textbooks used by our children remain with qualified educators, free of Federal influence; or should it be handled by the Federal Government?

We are headed toward the latter if we let the Community Relations Service get away with this proposed project—for then we will have given Office of Education a precedent to accelerate its plans for federally-written textbooks and a federally-controlled curriculum.

I have considerable doubt as to whether or not the Community Relations Service has the legal right to perform the function of rewriting textbooks to be used by our schoolchildren.

I support the idea for which the Service was created—that being to provide assistance to communities and persons in settling racial disputes—nothing more.

I strongly oppose any attempt by the Federal Government to dictate what will and what will not be in our textbooks because, in my opinion, this is not just a step down the road to a dictatorship, it is a giant's leap down that very road.

In a confidential memorandum, the Community Relations Service suggests:

> *"Once the educational and informational campaign is solidly underway, we should conduct a systematic effort to contact all publishers and school boards to encourage their publication and adoption of textbooks conforming to established standards."*

The term, "established standards," is a euphemistic way of saying it is going to set standards and censor the reading materials of our school system.

It is just as simple as that.

This Federal control of our schools was one of the main reasons that I had qualms about Federal aid to education and also the reasoning behind my decision to introduce the Pelly bill to give the schools needed aid without Federal controls, accomplished by returning to each State a portion of the amount its citizens pay in income taxes, each State to determine how these funds would be spent for education. There would be no strings at all.

When a dictator comes to power, the very first step he must take to consolidate that power is to capture the minds of the young—history presents this case in great depth.

> *How easy it can be when the Federal or Central Government controls the writing and censorship of textbooks!*

If the American people fully realized what Federal controls are planned for their schools, I am more than sure that we would hear one of the greatest outcries of protest and disapproval from the grassroots ever to echo in the Halls of Congress.

The Congress must investigate the facts before them—including the proposal to influence the contents of school textbooks.

I am sure this is what the American people will demand.

The time spent on developing just one new, efficient drug product—if only one person were involved in all the study and research—would require 19 working years—or 58,000 hours—of a research chemist's life.

* * *

Some four million children catch measles every year in the United States with about 500 deaths resulting. Serious complications may occur once in every 400 cases. Vaccines now can prevent this illness, even for babies as young as one month.

* * *

State Boards of Pharmacy usually approve persons who may register with the federal government to work as retail dealers in narcotics; thus the state boards are the cornerstone of control over retail sales of medicinal narcotics to the public.

* * *

It is estimated that 18 million of the 800 million prescriptions written in the U. S. this year will come from dentists. The average dentist writes more than 180 prescriptions a year.

* * *



volunteer for all seasons

There is no season for cancer. And fighting it is a year-round job for the American Cancer Society volunteer.

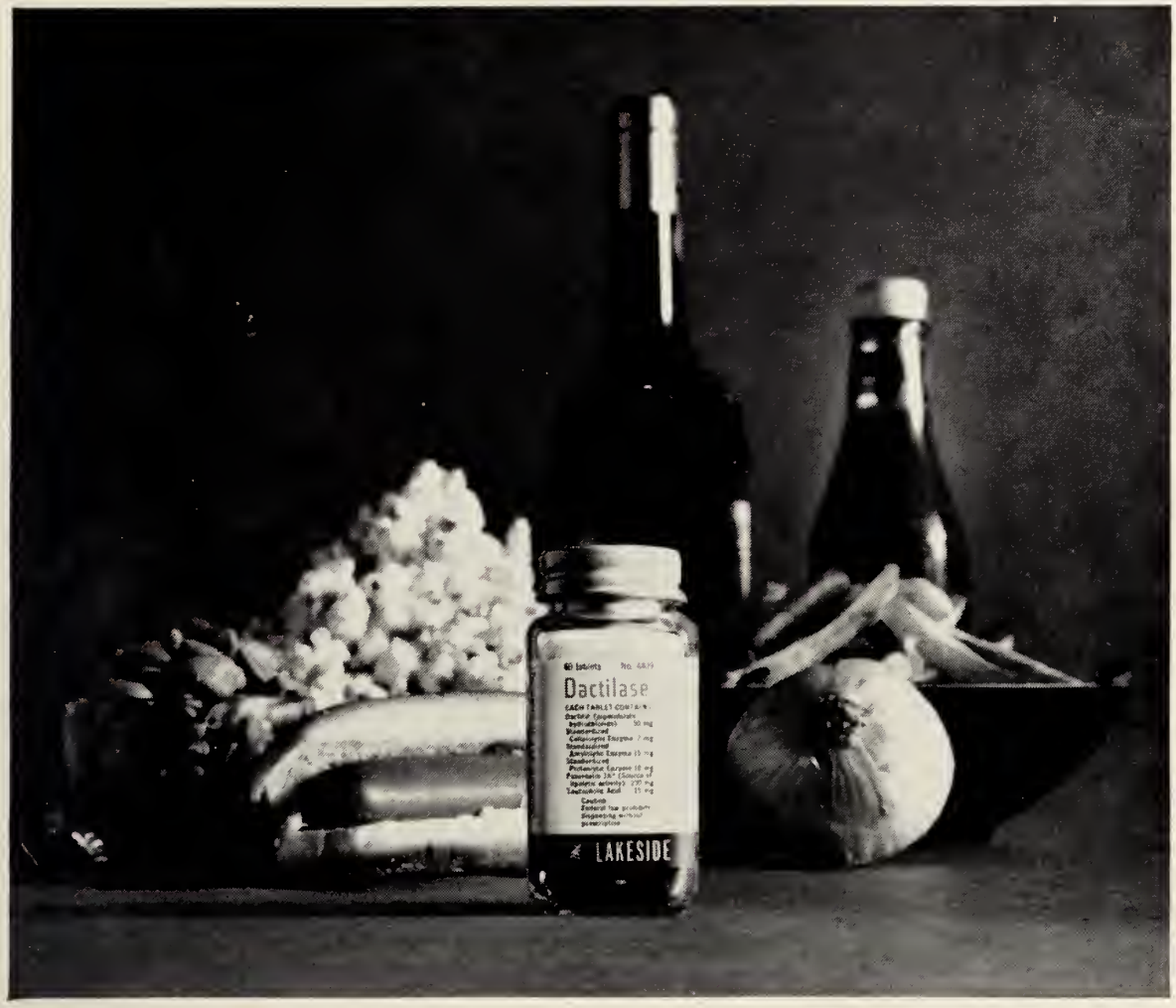
Particularly for you, doctor, our *key* volunteer. Your thinking, experience and guidance are responsible for the formulation of our policies and programs; your knowledge and skill are essential to their execution. And so you serve on our National, Division and Unit boards. Act on our committees. Talk to lay audiences at our film showings. Help evaluate our research grants. Advise on our professional publications. Raise funds. Assess our program materials. The list goes on and on.

The American Cancer Society keeps you busy, doctor. We depend upon you. We hope that more and more of your fellow physicians will join you in working with us—all year, every year until the fight against cancer is won.

AMERICAN CANCER SOCIETY®

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BIRMINGHAM 8, ALABAMA



more complete relief for the "dyspeptic"

DACTILASE®

Dactilase provides comprehensive therapy for a wide range of digestive disorders. Its antispasmodic and anesthetic actions rapidly relieve pain and spasm. Dactilase decreases hypermotility without inducing stasis. In addition, it supplies digestive enzymes to help reduce bloating, belching and flatulence. Dactilase does not interfere with normal digestive secretions. Very often it can be a most useful answer to the dyspeptic's needs.

DACTILASE: Each tablet contains: Dactil® (piperidolate hydrochloride), 50 mg.; Standardized cellulolytic* enzyme, 2 mg.; Standardized amylolytic enzyme, 15 mg.; Standardized proteolytic enzyme, 10 mg.; Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established. **As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

Side Effects and Contraindications: DACTILASE is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

ALABAMA HEART ASSOCIATION TO HOLD SCIENTIFIC SESSIONS

The 15th Annual Scientific Sessions on Cardiovascular Diseases sponsored by the Alabama Heart Association will be held in Birmingham March 9-10, 1966. The two day meeting will be at the Guest House Motor Inn and some of the nation's leading authorities will be on the program, (see below) including the current President of the American Heart Association, Dr. Helen Taussig of Baltimore.

All physicians in Alabama are invited to attend and it is expected that several hundred from this state as well as surrounding states will register for the meeting. There will be a registration fee of $5 for all except members of Alabama Heart Association, medical students, house officers, and qualified members of the Armed Forces. Registration will begin at 12:30 P. M. on March 9th. Advance registration may be handled by mail directly with the Alabama Heart Association, 2912 7th Avenue, South, Birmingham, Alabama 35233.

Speakers and their topics are as follows:

Wednesday afternoon, March 9th—1:45-5:00

"Natural History of Unoperated Congenital Malformations"—Helen Taussig, M. D.

"The Mechanisms of Hypertension"—Irvine Page, M. D.

"Cor Pulmonale"—John Hickam, M. D.

"Causes of Congestive Failure in Coronary Heart Disease"—Richard Gorlin, M. D.

"Unusual and Interesting EKG's—Part I"—Dave Littman, M. D.

Wednesday evening, March 9th—8:00-10:00

"Auscultatory Inferences Drawn from Non-Auscultatory Clinical Signs—Part I"—Joseph Perloff, M. D.

"The Treatment of Coronary Artery Disease"—E. S. Orgain, M. D.

"Surgery of Ischemic Heart Disease"—Dave Sabiston, M. D.

Thursday morning, March 10th—9:00-12:00

"Pathophysiology of Angina Pectoris"—Richard Gorlin, M. D.

"Office Approach to Patient with Pulmonary Emphysema"—John Hickam, M. D.

"Recent Developments in the Diagnosis and Management of Pulmonary Embolism"—Dave Sabiston, M. D.

"Unusual And Interesting EKG's—Part II"—Dave Littman, M. D.

Panel—"Pitfalls in the Diagnosis and Treatment of Surgical Heart Disease in Infants and Adults"—Drs. Perloff, Sabiston, Taussig and Gorlin.

Thursday afternoon, March 10th—1:30-4:30

"Indications for Surgery for Children with Congenital Malformations"—Helen Taussig, M. D.

"Current Diagnosis of Hypertension"—Irvine Page, M. D.

"The Treatment of Hypertensive Heart Disease"—E. S. Orgain, M. D.

"Auscultatory Inferences Drawn from Non-Auscultatory Clinical Signs—Part II"—Joseph Perloff, M. D.

Panel—"Complications of Drug Therapy in Hypertension and Ischemic Heart Disease"—Drs. Hickam, Littman, Orgain and Page.

TWENTY-NINTH ANNUAL MEETING THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

The twenty-ninth annual meeting of The New Orleans Graduate Medical Assembly will be held March 7, 8, 9 and 10, 1966, headquarters at The Roosevelt Hotel.

Nineteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include fifty-four informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, medical motion pictures, roundtable luncheons and technical exhibits.

This program is acceptable for twenty-nine (29) accredited hours by the American Academy of General Practice.

The twenty-first annual clinical tour of the Assembly has been planned for this spring to allow doctors and their families to enjoy a delightful vacation in combination with a medical program. Following the meeting in New Orleans, the group will leave on Saturday, March 12 for an AROUND THE WORLD trip via air. The itinerary includes Hawaii, Tokyo, Nikko, Kyoto, Nara, Hong Kong, Bangkok, New Delhi, Agra, Jaipur, and Cairo. The return flight is scheduled for Tuesday, April 12. Complete itinerary and rates will be furnished upon request.

For information concerning the Assembly meeting and tour write Secretary, New Orleans Graduate Medical Assembly, 1430 Tulane Avenue, Room 1528, New Orleans, Louisiana 70112.

A LETTER TO THE EDITOR

Dear Editor:

We have had several inquiries from local medical doctors desiring ICC physical examination forms and doctor's certificates. We do not have a stock of these in our office but they can be obtained at a small cost from the American Trucking Associations, 1616 P. Street, N. W., Washington, D. C. 20036.

The form for physical examination is P-101. Small quantities, 3c each; pad of 100 forms and over, 2½c each and 500 forms and over, 2c each.

The doctor's Certificate is also form PC-101, available at 3c each. This will, I'm sure, be a good item for your bulletin—a service rendered to your membership who made these examinations required by ICC regulations.

Sincerely yours,

Charles J. Burns, Director
Information & Safety

CJB:sh

Duke University Medical Center is developing a two-year program for residents in psychiatric care for older people. Clinical training will include case studies and supervised therapy of elderly patients.

Before preventive vaccines became available, measles killed approximately 84,000 children under five years of age in India in one year.

16 Ways to Kill an Organization

1 Don't attend meetings, but if you do, arrive late.

2 Be sure to leave before the meeting is over.

3 Never have anything to say at meetings; wait until you get outside.

4 When at meetings, vote to do anything, then go home and do nothing.

5 The next day find fault with your officers and fellow members.

6 Take no part in the organization affairs.

7 Be sure to sit in the back so you can talk things over with another member. Nobody will notice.

8 Get all the organization will give but give nothing in return.

9 Talk cooperation but never cooperate.

10 Never ask anyone to join the organization.

11 Threaten to resign at every opportunity; tell others they are standing far too much.

12 If asked to help, always say you haven't time.

13 Never read anything pertaining to the organization. You might find out too much.

14 Never accept an office. It is much easier to criticize.

15 If appointed to a committee, never give any time to the committee. Let the chairman do it all.

16 Don't do anything more than you have to and when others willingly and unselfishly use their ability to help the cause, howl because the organization is being run by a clique.

DEPROL®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

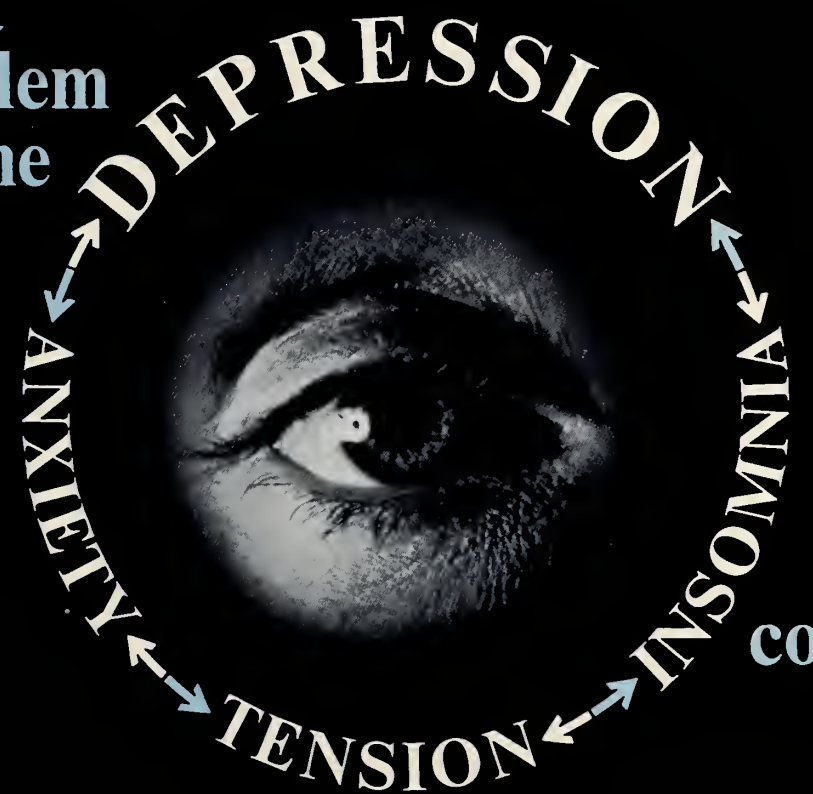
Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

Before prescribing, consult package circular.

WALLACE LABORATORIES / *Cranbury, N. J.*

CO-8726

When insomnia is a problem in the



complex

TRY DEPROL®–

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

A LOGICAL FIRST CHOICE

usually restores
normal sleep quickly
by helping
to lift depression...
calm associated anxiety,
tension, and rumination

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-5726

when even southern sun fails to warm cold hands and feet

provide rapid, sustained vasodilation for warmth and relief of pain, dizziness and faintness in patients with impaired peripheral circulation

GERILIQUID warms cold hands and feet through the thermogenic action of glycine and through sustained vasodilation by glycine and niacin. In addition, in patients with impaired peripheral circulation, GERILIQUID increases the ability to walk farther with less pain. Patients particularly like the palatable, sherry wine base.

Geriliquid®

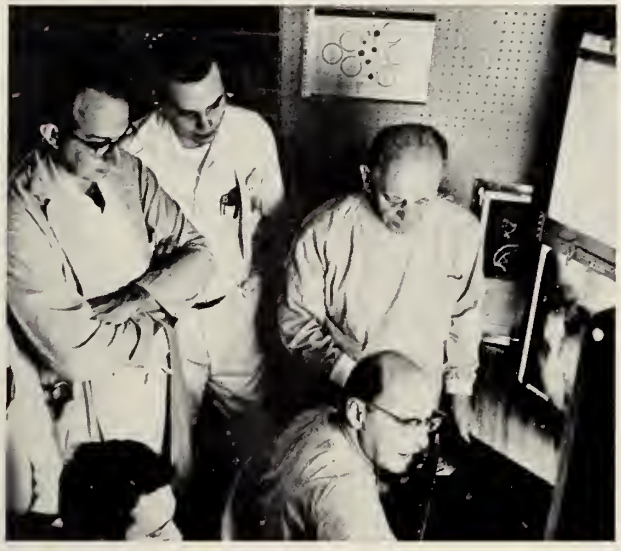


IN BRIEF: Composition: Each 5 ml. contains: niacin 75 mg. and aminoacetic acid (glycine) 750 mg. in a palatable sherry wine base; alcohol 5%.
Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.
Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.
Supplied: Bottles of 8 oz. and 16 oz.

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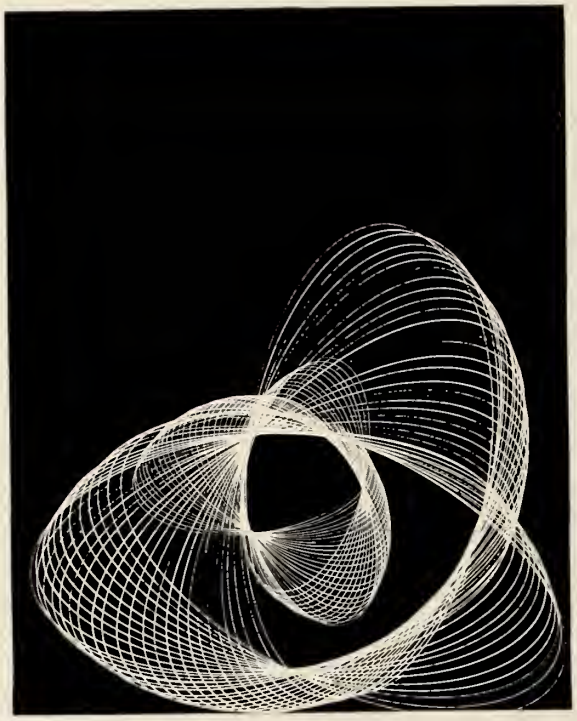
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Because AMA-ERF embodies significant programs in both education and research—programs that reach out to touch the practice and performance of medicine in the future.

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AMA-ERF's Loan Guarantee program is making it possible for thousands of students, interns, and residents to continue their medical training by borrowing without public subsidy.

AMA-ERF's Institute for Biomedical Research is providing the kind of setting scientists need to probe the mysteries of the living cell and the life process.

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AMA-ERF

ALCOHOL AND CHRONIC ILLNESS

A recent investigation headed by a staff member of the Medical School of the State University of New York at Buffalo has shown that alcoholism may be more prevalent as a factor in other illnesses requiring hospital admission than previously thought. It was found that alcoholics were treated on the general medical wards for the acute illnesses that brought them there, while the underlying difficulty of alcoholism was often untreated.

The study of 900 consecutive admissions, covering 826 patients, in three teaching wards of the Grace-New Haven Hospital, New Haven, Conn., found 13.8 per cent of admissions to be significantly related to alcoholism. In about 75 per cent of these cases the addiction to alcohol contributed directly to the ailments necessitating admission.

The most common presenting illness in the 124 admissions of 108 alcoholic patients was acute bacterial pneumonia in 21 instances, or 17 per cent of admissions. Only 6.5 per cent of the non-alcoholic patients had this ailment. Other diseases in the alcoholic patients where rates of incidence were significantly higher than those in the non-alcoholic patients were cirrhosis, acute or chronic pancreatitis, seizures, acute gastritis, and pulmonary tuberculosis.

The investigators concluded that there was a cause-and-effect relationship between alcoholism and the presenting illnesses in 90 of the 124 admissions of the addicted patients, or 10 per cent of the entire series. This was believed to be a conservative estimate.

It was the opinion of the chief investigator that physicians should be encouraged to follow up on cases of alcoholism after the patient has been discharged from the hospital. This would be one method of attempting to treat the underlying problem in the acute illness.

Reprinted from the *Chronic Illness Newsletter*, December, 1965.

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A REAPPRAISAL OF BARTHOLIN'S GLAND

Buford Word, M. D.

Operations that restore function to an impaired Bartholin's gland and at the same time are curative for cyst and abscess of its duct are preferable to excision or cautery destruction of this organ. Cysts and abscesses are, for the most part, lesions of the gland duct caused by occlusion at the vestibular orifice. Accumulation of secretion causes the duct to dilate until back pressure impairs the acini cells' ability to secrete. The situation is similar in abscess formation, but is complicated by all the evils of an acute inflammatory process. Treatment is aimed at intraluminal tamponade of the gland secreting cells by providing adequate permanent drainage for their secretion. A simple operation that restores function to a physiologically desirable gland is described and recommended.

Three centuries ago Caspar Bartholin accurately described the location of the paired greater vestibular glands and dramatically related their function to coitus. His original description, published in 1677, has made the name of Bartholin and the greater vestibular glands inseparable. In 1685 the same Caspar Bartholin described the larger collecting duct of the sublingual gland, and today all medical dictionaries designate Bartholin's duct as located in the floor of the mouth and Bartholin's gland as located in the female external genitalia. To use correct terminology in diagnosing certain lesions of the vulva it must be appreciated that Bartholin's duct is not attached to Bartholin's gland. A cyst of Bartholin's gland is, for the most part, a nonexistent entity. A cyst of Bartholin's duct is a ranula in the floor of the mouth occurring in both men and women. A cyst in the external genitalia of the duct apparatus of the greater vestibular gland is a cyst of Bartholin's gland duct.

An understanding of the anatomy and physiologic function of an organ is necessary to comprehend the pathology of diseases that impair the organ. Such knowledge is of the essence in implementing the most desirable curative treatment.

Anatomic Considerations. Bartholin's glands are paired organs located in the female external genitalia between the superficial and deep perineal compartments. The glands lie inferior but immediately adjacent to the vestibular bulbs. They are covered

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Reprint requests to 924 18th Street, South, Birmingham, Alabama 35205.

successively by the bulbocavernosus muscle, the inferior perineal fascia, the deep and superficial fascial layers and skin. The duct of Bartholin's gland is approximately one inch long and courses obliquely beneath the distal end of the labia minora to empty into the vestibule adjacent to the hymenal ring in the mid-lateral area of the vaginal introitus.

The glands are racemose and the acini are lined with a single layer of secreting cuboidal cells. The main duct of this gland and its larger collecting branches are lined with a transitional or pseudo-stratified type of epithelium. Immediately adjacent to the basement membrane of the duct are several layers of stratified transitional epithelium which is superficially covered by a layer of pear-shaped columnar cells that line the duct lumen. The distal end of the duct is lined completely with stratified squamous epithelium for a few millimeters. This makes the vestibular aperture of the duct a squamo-mucosal structure on the duct side as well as the vestibular side. Most of the vestibular surface is covered with stratified squamous epithelium of the mucosal type. Cutaneous epithelium covers only the outer one-half of the medial surface of the labia minora, which is well away from the duct opening.

Function. Bartholin assumed the function of the glands he described was lubrication for enhancement of sexual intercourse and that secretion from these glands flowed freely only during sexual stimulation. His opinion has been accepted through the years as fact. In 1960 Masters[1] challenged this age-old belief and stated the amount of fluid secreted by these glands during sexual excitement was insufficient and came too late to be of great benefit as a lubricant. He states the fluid produced in the genital tract incident to sexual stimulation is a sweating phenomenon of the vaginal mucosa, probably due to vasocongestion of the vascular network surrounding the vaginal canal. Masters' experiments have not been confirmed, neither have they been disproved.

From a practical viewpoint it appears that if Bartholin's glands should secrete freely, as claimed, during sexual stimulation, cysts of the ducts would develop suddenly and usually at the time of coitus. The author has been unable to connect the initial development of a cyst or its subsequent enlargement to sexual activity.

It is the author's opinion the major function of Bartholin's gland is to keep the vestibular surface of the vulva moist at all times. This it does by secreting continually. Evidence supporting this view is noted by observing patients who have had a unilateral Bartholinectomy. On the affected side the vestibular wall is dry and scaly and has the appearance of a cutaneous surface. On the unaffected side the tissues are moist, resilient and healthy. Such patients admit to unilateral discomfort during the initial phase of intercourse because of dryness.

It is a fact the vulva is moist in cases of congenital absence of the vagina and the ever present secretion is apparently supplied by these glands.

The Bartholin's gland does not function prior to puberty, and the lack of its slippery secretion may be the cause of vulval synechia seen in little girls, a condition not observed after puberty.

Another observation supporting the sweating phenomena of the vaginal mucosa during sexual excitement and continual secretion of Bartholin's gland in its absence, is noted in examining patients who have had simple vulvectomy. The perineum and lower vagina appear extremely dry, with no evidence of secretory activity. In questioning such patients they state the dryness is no hindrance to coitus. In fact, they say the genital tract is not dry at that time.

Pathology of Cyst and Abscess. Cyst of the gland duct develops as a result of occlusion of the duct ostium. The gland continues to secrete and the duct dilates to form a reservoir for the fluid. The duct is capable of dilating because its wall is stratified. The

acini of the gland cannot dilate to form a cyst because they are lined with a single cell layer of cuboidal epithelium. When intraluminal pressure of the acini is raised either by occlusion of its individual collecting branch or back pressure from occlusion of the main duct, ability of the gland cells to secrete is impaired and function is suspended. The acini cannot dilate and do not secrete unless there is storage for the secretion. A cyst that recurs following Bartholinectomy is due to incomplete removal of the gland, and that portion remaining has a well-stratified branch of the duct collecting system attached.

Abscess of the gland is due to infection, either pyogenic or gonorrheal. If the abscess is secondary to cyst formation it is usually due to pyogenic organism. If the abscess is primary and bilateral the possibility of gonorrheal infection is suggested. In primary abscess formation the edema of the inflammatory process occludes the ostium and the duct dilates and completely disintegrates if the abscess continues to expand. The expansion may be anterior and posterior, but is superficial to the deep layers of fascia beneath which the gland is buried, indicating minimal involvement of the gland and major involvement of the duct system. The duct regenerates after the inflammatory process subsides.

Differential Diagnoses. All perineal tumors located beneath the posterior end of the labia minora are not necessarily lesions of the gland or its duct, although cyst and abscess of this structure are by far the most common tumors of the vulva. Lesions that must be differentiated from cyst and abscess are enterocele pointing in the area, perineal hernia, ischiorectal abscess, large sebaceous cyst, hydrocele of the canal of Nuck, fibroma of the diverticular apparatus, pudendal hematoma, and metastatic carcinoma, particularly from a chorionepithelioma and carcinoma of the rectum, and finally primary cancer must be considered in the differential diagnoses of every lesion of this vulval structure.

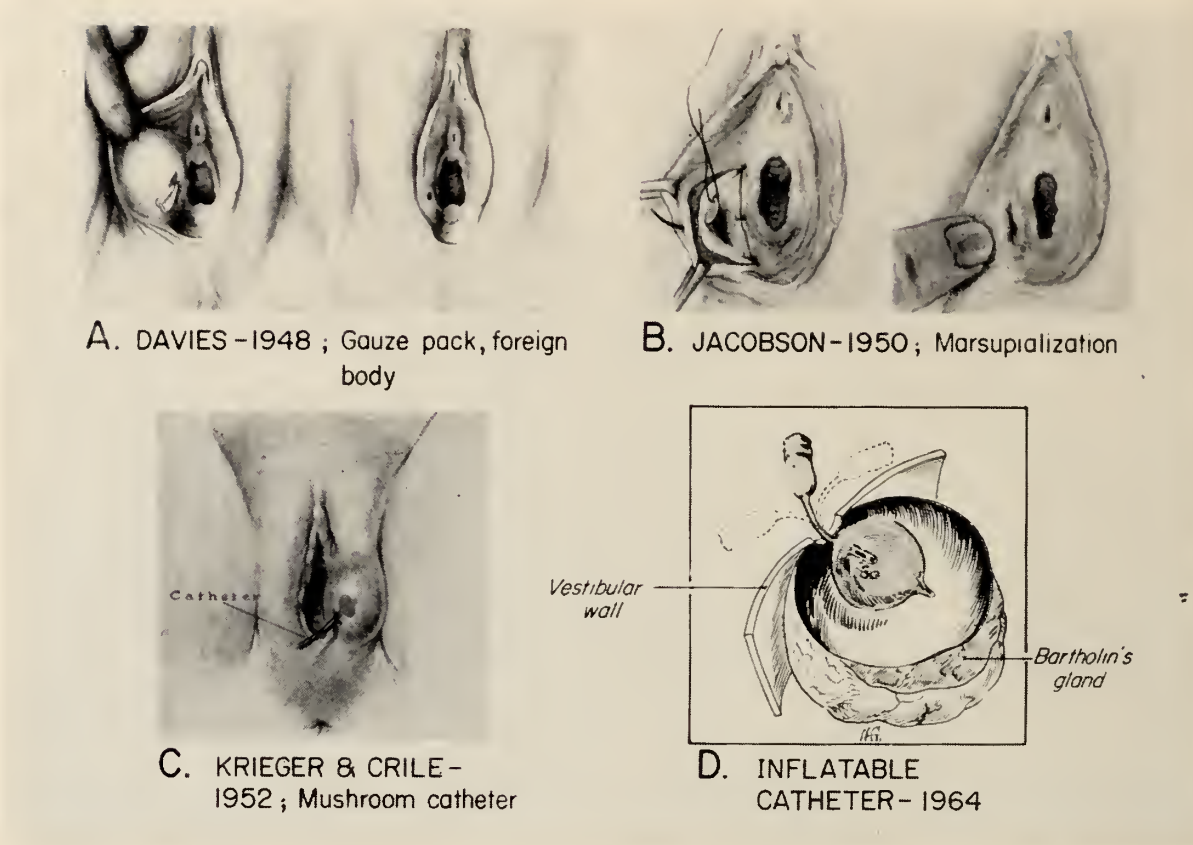
Barclay and associates,[2] in reporting 152 cases of Bartholin's gland cancer, included all cases found in the world literature up to 1964.

The same number (152) of cyst and abscess of the gland duct were seen in one community hospital in Petersburg, Virginia, by Jacobson and colleagues[3] over a 10- to 15-year period. The 140 patients who possessed the 152 cysts and abscesses were all treated by marsupialization. The number of patients seen with the same lesions during this period of time, but treated by other methods, was not stated. Although cancer of this organ is rare when compared to the common benign lesions, it is essential to collect material for cytology studies and biopsy from all suspect lesions.

Methods of Treatment of Cyst and Abscess. Ideal treatment for patients with a diseased organ is that which restores function when possible and practical. The retrieval operations for cyst and abscess of Bartholin's gland duct have made excision and cautery destruction of this organ obsolete operations.

The author's interest in a method of treatment that would result in the formation of a permanent epithelized fistula between the duct and the vestibular mucosa began in 1938, with an appointment as an outpatient staff attendant in the Hillman Hospital Gynecologic Clinic. A desire to render definitive care to patients on an ambulatory basis was the initial motivating factor. The first type foreign body hopefully used in an attempt to produce a fistula was a large braided silk loop that perforated the cyst in two places and was loosely tied to dangle from the vulva. Theoretically two openings would result instead of one. There were no successes by this method because patients complained of its presence and were too impatient for results.

Next a triangular metal ring was used, the item farmers employ to ring pigs' noses. The ring was cumbersome to insert and more so to remove, which was done on two occasions several hours later because of patient discomfort.



Legend for Fig. 1

Operations that restore function to Bartholin's gland and are curative for cyst and abscess of its duct.

Later a spring-type V-shaped brad was inserted into a cyst through a single stab wound. The brad also caused discomfort and no patients allowed the instrument to remain in place long enough to effect creation of a permanent new opening. All foreign body items were inserted for the purpose of preventing closure of the puncture or stab wound until an epithelized fistula was formed. Faith in the foreign-body method of creating an everlasting fistula was maintained by observing women wearing toothpicks, broom straws and thread in pierced ears to aid epithelization of the puncture wound. A foreign body that could be inserted without difficulty, worn with comfort and removed with ease appeared a prerequisite for success.

Gauze Pack Foreign Body

Joshua W. Davies[4] of New York, in 1948, was the first to recognize that excision of a Bartholin's gland produced an unsatisfactory result. He recommended a procedure to restore function in treating cyst and abscess of this organ. Following a stab wound into the cyst (Fig. 1-A) he packed the cystic cavity twice weekly for three weeks with iodoform gauze, at which time epithelization of the new ostium had occurred, after which the gland resumed normal function.

Marsupialization

Philip Jacobson,[5] in 1950, first described marsupialization (Fig. 1-B) of cysts of the gland duct to preserve and restore function. In Jacobson's[3] hands this operation failed

only four times in the treatment of 140 patients who collectively had 152 cysts and abscesses.

In the hands of others[6] the cure rate of the marsupialization method has been less spectacular.

Mushroom Catheter

Krieger and Crile,[7] in 1952, described a method of treating cyst of the duct of Bartholin's gland by inserting a mushroom catheter (Fig. 1-C) as a self-retaining prosthesis. They recommended the method because it was simple and preserved the function of a physiologically desirable gland.

Inflatable Bulb-Tipped Catheter

The author[8] recently described a bulb-tipped inflatable catheter developed for use as a foreign body in creating a new orifice for the duct affected by cyst or abscess. The instrument is pictured in situ in Fig. 1-D.

By comparing the methods of treatment pictured in Fig. 1, it is readily seen that the inflatable bulb-tipped catheter is a refined echo of the mushroom catheter technique recommended by Krieger and Crile.

Prior to development of this instrument a small Foley catheter was used, and the lining of the cyst was sutured to the vestibular mucosa. It was noted, however, these sutures soon sloughed and were more a hindrance than a benefit. Since the cyst is distended by the inflatable instrument, its incised edges are maintained in apposition with the vestibular mucosa and make sutures unnecessary. The type of foreign body that prevents the stab wound edges from closing is immaterial. It is of utmost importance to use a foreign body that can be worn by the patient without complaint. I have used this method in 60 cases with no adverse sequelae and no complications.

Case Report

In the latter part of 1964, while awaiting a second shipment of inflatable catheters, an obstetrical patient near term developed an uninfected cyst of the gland duct on the right side. Desiring to observe what happened to the catheter in situ during the process of obstetrical delivery, the fifth finger of a latex glove was used as a foreign body. With a large, blunt spinal needle the glove finger was tied about the needle, inserted through a stab wound, and inflated with water. A cotton quilting thread around the latex glove finger and needle contained the water as the needle was withdrawn. The ligature was tied securely and the excess of the latex glove trimmed flush with the ligature, which was also flush with the vestibular mucosa. Precisely, a small water balloon had been inflated in the cyst, with a small knot on one side about the size of a pencil eraser, and the knot rested in the fresh stab wound. Two weeks following this office procedure the patient went into labor and delivered a healthy 6 lb. 15 oz. female infant spontaneously. As the vertex parted the vulva the water balloon appeared to rise up from its normal location, as both labia minora at this time became completely horizontal like the wings of an airplane and the water balloon rose with the right labia and was just underneath its distal end during the birth process. No part of the baby at any time during the delivery was near the inflated balloon. There appeared to be no stress on the tissues on either lateral side of the vulva in spite of the fact the patient obtained a 3° perineal laceration due to attention received by the inflated latex glove finger tip. Repair of the 3° laceration was done and healing occurred without complications. The patient was seen in the office six weeks following delivery with the balloon in place and the new orifice of the duct appeared well epithelized. The water was withdrawn with a needle and the collapsed glove finger tip removed. The new orifice was well healed. The patient was checked six months following delivery and a well-epithelized orifice was present. The duct was probed to a normal depth and the gland appeared to be functioning, as the vulva was moist on both sides.

This case report demonstrates the foreign

body used does not necessarily have to be a sophisticated one if judged by results alone. The inflatable catheter, however, eliminates the clumsiness associated with the insertion of various gadgets, including a Foley catheter as well as the finger of a worn-out glove.

Advice to Users of the Inflatable Catheter

1. The catheter bulb is made of durable latex and the bulb end is blind. Drainage occurs through the stab wound around the catheter stem. The opposite end of the catheter has a sealed stopper, and this is the end that is turned upward to rest in the vagina.
2. Do not make the stab wound in cyst or abscess too large or the catheter may work its way out.
3. Use water to inflate catheter bulb, only enough to prevent it from becoming dislodged. Three to 5 cc. will usually suffice. Air will not maintain inflation of catheter bulb.
4. Do not use a local anesthetic in the wall of an abscess because of the danger of spreading infection.
5. To assure success leave the catheter in longer than you think necessary. Four to six weeks is the usual time.
6. Pregnancy is no contraindication for its use.
7. It may be inserted immediately following delivery.
8. Sexual relations may be allowed after tenderness subsides. This activity will take place anyway, in spite of advice to the contrary. The patients say it makes no difference.

Advantages of Bulb-Tipped Inflatable Catheter Method

1. Simple to perform.
2. No hospitalization.
3. Minimal discomfort.
4. No disability.
5. No residual deformity.
6. No morbidity.
7. No complications.
8. And most important, restores normal function to a desirable organ.

Acknowledgements

The catheters used in this study were supplied by the American Cystoscope Makers, Inc., Pelham Manor, New York.

Photographs in Fig. 1-A, B, C, and D reproduced by permission from the following publications:

Fig. 1-A *Surgery, Gynecology & Obstetrics* (86:330 (Mar.) 1948.)

Fig. 1-B *Western Journal of Surgery, Obstetrics and Gynecology* (58:706 (Dec.) 1950.)

Fig. 1-C *Cleveland Clinic Quarterly* (19:72 (Apr.) 1952.)

Fig. 1-D *The Journal of the American Medical Association* (190:777 (Nov. 23) 1964.)

References

1. Masters, W. H.: Sexual Response Cycle in the Human Female I. Gross and Anatomic Considerations, West. J. Surg. Obstet. Gynec. 68: 57-72 (Jan-Feb) 1960.

2. Barclay, D. L.; Collins, C. G.; and Macey, H. B. Jr.: Cancer of the Bartholin Gland; A Review and Report of 8 Cases, Obstet. Gynec. 24: 329-336 (Sept) 1964.

3. Jacobson, P.: Marsupialization of Vulvovaginal (Bartholin) Cysts; Report of 140 Patients with 152 Cysts, Amer. J. Obstet. Gynec. 79: 73-78 (Jan) 1960.

4. Davies, J. W.: Bartholin Cyst; Method for Its Restoration to Function, Surg. Gynec. Obstet. 86: 329-331 (Mar) 1948.

5. Jacobson, P.: Vulvovaginal (Bartholin) Cyst; Treatment by Marsupialization, Western J. Surg. Obstet. Gynec. 58: 704-708 (Dec) 1950.

6. Oliphant, M. M. Jr. and Anderson, G. V.: Management of Bartholin-Duct Cysts and Abscesses, Obstet. Gynec. 16: 476-478 (Oct) 1960.

7. Krieger, J. S. and Crile, G., Jr.: Bartholin's Cysts, Cleveland Clin. Quart. 19: 72-73 (Apr) 1952.

8. Word, B.: New Instrument for Office Treatment of Cyst and Abscess of Bartholin's Gland, JAMA 190: 777-778 (Nov 23) 1964.

INJURIES OF THE FACE AND JAWS

Bruce F. Holding, Jr., M. D. and John C. Sullivan, M. D.

Montgomery, Alabama

An epidemic of death and disfigurement is sweeping through Alabama. Last year 1031 persons were killed in motor vehicle accidents in our state.

There are three prime factors contributing to the rising auto crash rate. These are:

1. Speed
2. Increase in the number of automobiles
3. Failure in driver performance

When we refer to speed, we are not speaking of speeds in excess of the legal limit. Thirty or 40 miles an hour is speed. It is well known that more than one-half the accidents causing injuries and death involve speeds of less than 40 miles an hour. The frantic pace of our civilization has made speed in transportation essential. The force of impact at 35 miles an hour is twice that of 25 miles an hour; at 65 miles an hour the impact is 600 times that of 25 miles an hour.

The rising number of automobiles on our streets and highways is already a major problem of traffic control. The dilemma increases hourly. The output of autos by Detroit is twice as great today as it was six years ago.

For the year 1954 in Alabama, there were 876,670 registered vehicles.

In 1964, there were 1,529,876 autos registered in our state, for an increased ratio of approximately 75 per cent.

Theoretically speaking prior to 1954 your opportunity, in Alabama, for hitting another auto at a four way intersection was relatively slight. By 1954 chances were there was another car at the intersection at the same time. Ten years later by 1964, there were two cars waiting for you at the intersection. If this same ratio holds true by 1974, the same two cars will be waiting to smash you as you try to avoid the two car collision just happening.

The magnitude of the problem can be presented in other ways.

In the nation as a whole in the year 1960 there were 38,200 auto deaths and 140,000 injuries. The total cost to the nation was about 6.5 billion dollars, including 1.65 billions in loss of wages and 150 millions in medical expenses.

At least for the present, in spite of the stepped up efforts on the part of all traffic control agencies, despite the vastly improved roads, and the better equipped motor vehicles, the accident rate will continue to climb. If we accept the fact that automobile crashes are inevitable, then one measure we must utilize to the utmost is the protection of the passenger in the automobile.

Genuine advances have been made in re-

This manuscript was delivered by Dr. Holding at the annual meeting of the Medical Association of the State of Alabama, Birmingham, in 1965.

cent years in improving auto design. The extent that the auto industry has participated in safety leadership appears to be controversial.

Emphasis on auto safety design had its beginning in 1940 from Hugh DeHaven, a research physiologist at Cornell University. He became interested in freak survivals following free falls and suicide attempts. He applied these factors to the packaging of the pilot in the airplane cockpit during World War II. His results were so outstanding in decreasing pilot injury that, after the war, his research turned to the automobile. Based primarily on these studies, certain suggestions concerning the basic improvement in auto design and equipment were made.

1. Use of safety belts for all passengers
2. Improved interlocking door latches to prevent opening on impact.
3. A dish shaped steering wheel
4. Fixation of the front seat to the chassis, to prevent the additional weight of the seat from being thrown with the passenger against the front of the car
5. Padding of the dash and instrument panel
6. Elimination of protruding objects

Safety features are not popular with the average automobile buyer. One auto manufacturer, nine years ago, centered its advertising campaign on certain new safety features. The direct result was a severe drop in new auto sales. Obviously this approach is not for the automobile manufacturers.

The Cornell University group has shown from its study of 5,959 automobile accidents involving 13,316 occupants that 74.9 per cent of these occupants were injured. Of this total, 72 per cent suffered injuries to the head. Included in this list of injuries to the head were disfiguring soft tissue injuries, injuries of the occular globe, transection of the facial nerve, fractures of the facial bones and jaws, and bones of the cranium.

This high percentage of head injuries would seem to substantiate the impression by various clinicians of the prodigious increase of facial injuries.

Analysis of these national figures caused us to wonder about the maxillo-facial injuries in our locality.

In our home town of Montgomery, we reviewed the charts of St. Margaret's Hospital and found that ten years ago, in 1954, the number of maxillo facial injuries recorded as such and admitted to the hospital was 42. The number of similar injuries for last year, 1964, was 156. An increase of almost 368 per cent.

Time motion characteristics of auto passengers undergoing auto crash deceleration have been analyzed as to those factors productive of maxillo facial injuries. The initial motion projects the occupant forward and upward at angles approximating 45 degrees. This accelerated motion ceases instantly when a major portion of the body strikes the interior of the auto such as the windshield, steering wheel or dash.

Safety belts have been particularly effective in preventing injury and death in automobile accidents. However, the effectiveness of the conventional seat belt has definite limitations in the prevention of maxillo facial injuries (Fig. 1a). The so called "three point



Figure 1a—Conventional seat belt does not prevent impact of face with dash.

belt" or Scandinavian Belt, which provides an over the shoulder restraint in addition to the lap belt would seem to afford far greater protection (Fig. 1b).



Figure 1b—"Three Point Belt" affords greater protection."

Now let's examine a few of the more frequent types of maxillo facial injuries.

1. Soft Tissue Facial Injuries (Figs. 2a-2b)

When the passenger is hurled into a non-shatterable windshield, a characteristic type of disfigurement ensues. The head crashes through the windshield and during the down swing or the return of the head back into the car, the soft tissues of the face are actually avulsed from the bony framework.



Figure 2b—Windshield victim after multiple stage surgical correction.

2. Naso Orbital Fractures (Figs. 3a-3b)

Fractures of the nose although the most frequent of the facial complex are also the most neglected. This problem has been analyzed in a previous publication by us.



Figure 2a—Windshield injury.



Figure 3a—Neglected naso-orbital injury.



Figure 3b—Postoperative result achieved in one-stage technique.



Figure 4b—The underlying bony defect, that would result in severe deformity if uncorrected.

3. Fractures of the Zygoma (Figs. 4a-4b-4c)

The early recognition of this injury is frequently difficult. This is due to deceiving edema filling the depressed contour.



Figure 4a—Multiple comminuted fracture of zygomatic complex presenting as innocuous "black eye."



Figure 4c—Results of combination open and closed techniques in reduction of zygomatic fragments.

4. Fractures of the Mid Face (Figs. 5a-5b-6a-6b-6c)

Some of the most disfiguring of all facial injuries result from trauma to this area. These are the most difficult to restore. Frequently the facial skeleton is so macerated that the combination of fractures defies all description. The surgical restoration of these fractures demands intimate working knowl-



Figure 5a—Complex fractures of "mid third" facial elements, combined with bilateral fractures of mandible.



Figure 5b—Patient after one-stage surgical reduction.



Figure 6a—Typical appearance of patient with cranio-facial dysjunction of maxilla—notice the elongated "sorrowful" facies and spinal fluid visible in left nares.



Figure 6b—Profile view showing proper relationship of facial components. This external traction device is affixed to the intact cranium by four point screw fixation.

edge of a variety of approaches, such as elevation of depressed fragments, direct multiple inter osseous wiring of fragments and suture lines, restoration of function and contour of para nasal sinuses, various techniques for splinting the maxilla to the mandible, fixation of the maxilla to one or more stable points on the cranium itself.



Figure 6c—Four weeks following injury.



Figure 7b—Appearance after implant of nasal septum cartilage into the floor of orbit, restoring function and appearance.

5. Blow Out Fractures of the Orbit (Figs. 7a-7b)

This entity usually occurs when blunt trauma is applied to the occular globe. But it is not infrequently associated with other fractures of the facial skeleton. The globe is compressed and most often escapes injury itself. The thin bony lamina of the orbital floor "blows out" with resulting herniation of the occular fat into the adjacent maxillary and ethmoid sinuses. As the edema subsides characteristic signs of occular involvement appear. These are enopththalmos, diplopia and restricted motions of the eye. The defect is corrected by restoring the integrity of the orbit by suitable reconstruction of the floor with bone or cartilege grafts or with Silicone implants.



Figure 7a—Patient with "blow out" fracture of orbit. Notice the eye appears small.

6. Facial Nerve (Figs. 8a-8b)

The external branches of the facial nerve are often lacerated. The mandibular branch causing deformity of the lower lip is most frequently involved. The surgical microscope, originally designed for Otologic Surgery is used to advantage in anastamosing these segments.

Complete facial paralysis may occur due to compression of the facial nerve in the fallopian canal as it traverses the middle ear and mastoid. This situation presents in "basilar skull" fractures where the fracture line extends into the middle ear from the petrous portion of the temporal bone. Surgical decompression of the facial nerve in the middle ear is a valuable technique. Oftentimes the



Figure 8a—Left facial paralysis due to compression of facial nerve by bone fragments in middle ear—"Basilar skull fracture."



Figure 8b—Patient three weeks after decompression of facial nerve through middle ear approach.

accompanying deafness can be corrected at the time of the facial nerve decompression, by tympanoplasty.

7. Fractures of the Mandible

Fractures of the lower jaw are excluded from discussion here and will be the source of a separate report by us. There is a definite new concept developing in the treatment of fractures of the mandible whereby the post-operative morbidity associated with four to six weeks of inter-dental wiring is eliminated.

Conclusions

Many patients sustaining injuries of the maxillo facial complex have concomitant crushing injuries to the extremities, thorax, pelvis, spine or abdomen. Every physician who handles such trauma is faced with the problem of how best to care for such a patient. Certain basic principles with which we are all familiar, such as control of hemorrhage, splinting of fractures, and providing adequate pulmonary function, are tested and proved. The second phase of surgical rehabilitation of such patients may require meticulous attention to each organ system so damaged.

In times past, facial injuries were usually delegated a low priority in terms of rehabilitation of the multiply damaged patient. Our society accepts post traumatic defects as increasingly commonplace. On the other hand, the person with facial disfigurement is often socially rejected and not only suffers functional and psychological frustrations, but suffers vocational problems as well. The surgical correction of facial deformities can no longer be arbitrarily postponed. The appropriate sequence of approaches to the multiply injured patient is usually trying, but it must be personalized to the particular advantage of each patient.

References

1. Converse, J. M.: Facial Disfigurement in Automobile Accidents, JAMA 185: 354.

2. DeHaven, H.: Cornell Starts Active Summary of Indiana Auto Crash Injury Reports, J. Indiana Medical Association 46: 414, 1953.

3. Safety Factors in Driving, The Physicians Panorama I: 9, 1963.

4. Wade, P. A. and McLaughlin, H. L.: Automobile Crash Injuries, Medical Science 12: 112, 1962.

5. Holding, Jr., B. F.: The Neglected Nasal Fracture, Jour. of Med. Assoc. of St. of Ala., Vol. 32, Feb. 1963.


Flagyl destroys trichomonads
here & here & here & here
No topical treatment can

Flagyl®
brand of
metronidazole

Flagyl eliminates the difficulties and frustrations that have long attended the treatment of trichomonal infection.

These difficulties arose mainly from:

1) the failure of any previously known agent to destroy the protozoan in paravaginal crypts and glands;

2) the failure of any previously known agent to prevent reinfection by eradicating the disease in male consorts.

The introduction of Flagyl removed both of these long-standing deficiencies. Hundreds of published investigations in thousands of patients have confirmed the ability of Flagyl to cure trichomoniasis.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced a cure rate of up to 100 per cent in large series of patients.

Nothing cures trichomoniasis like Flagyl.

Dosage and Administration

In *women:* one 250-mg. oral tablet t.i.d. for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When the inserts are used one vaginal insert should be placed high in the vaginal vault each day for ten days, and concurrently two oral tablets should be taken daily.

In *men:* in whom trichomonads have been demonstrated, one 250-mg. oral tablet b.i.d. for ten days.

Contraindications

Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precautions and Side Effects

Complete blood cell counts should be made before and after therapy, especially if a second course is necessary.

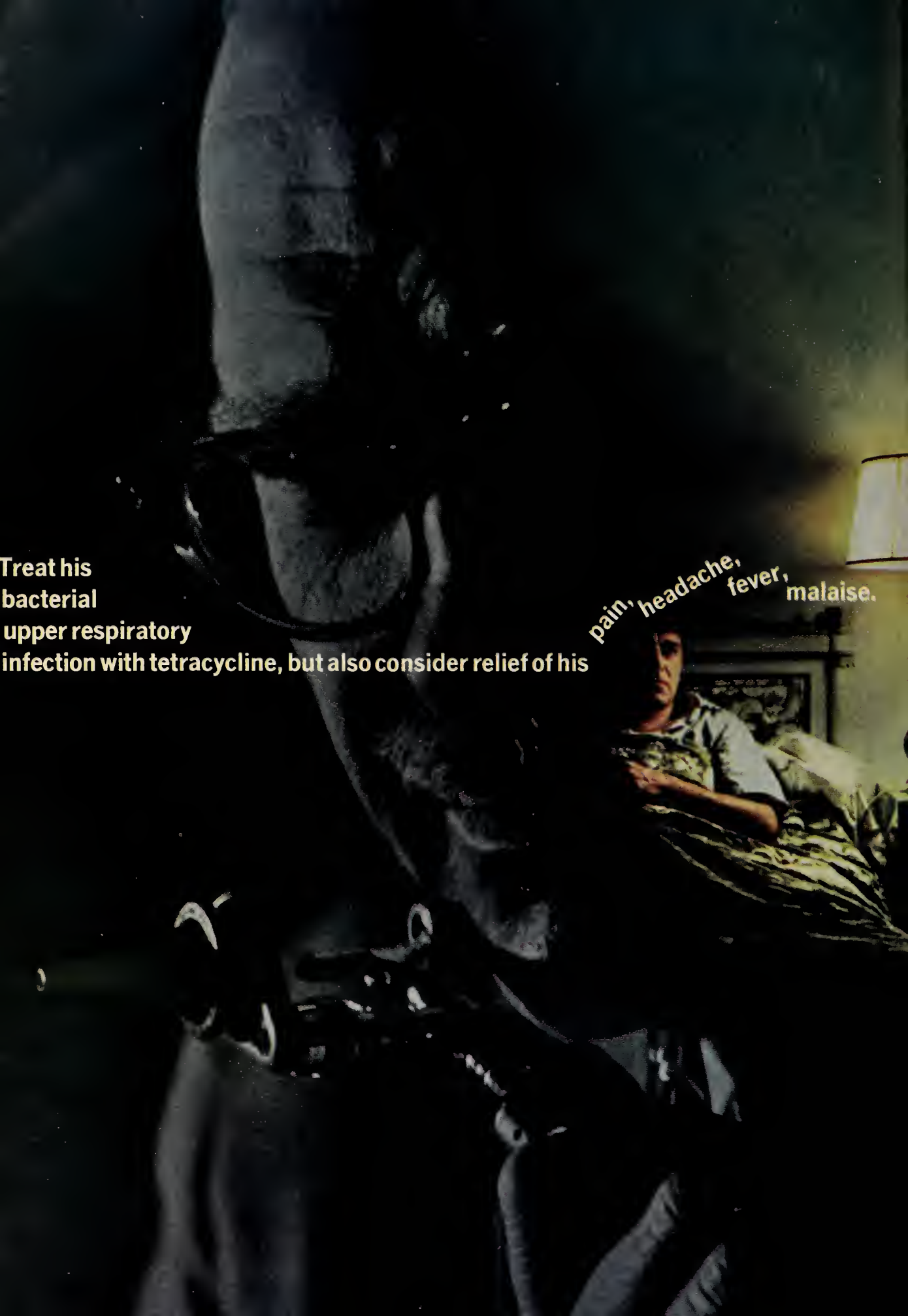
Infrequent and minor side effects include: nausea, unpleasant taste, furry tongue, headache, darkened urine, diarrhea, dizziness, dryness of mouth or vagina, skin rash, dysuria, depression, insomnia, edema. Elimination of trichomonads may aggravate moniliasis.

Dosage Forms

Oral—250-mg.tablets/Vaginal—500-mg.inserts

SEARLE

Research in the Service of Medicine


Treat his
bacterial
upper respiratory
infection with tetracycline, but also consider relief of his
pain, headache, fever, malaise.

Effectively combat bacterial infection and maintain relief of respiratory symptoms

Tetrex®-APC

with Bristamin®

(tetracycline phosphate complex with analgesics and antihistamine)

The advantages of Tetrex® (tetracycline phosphate complex). It contains the basic tetracycline which is less bound to serum protein than is demethylchlortetracycline[1]. (It puts a higher percentage of active antibiotic into the blood.) Its basic tetracycline is also better tolerated than oxy- or demethylchlortetracycline.[2,3] *Unlike demethylchlortetracycline,[4] no cases of photodynamic skin reaction have been reported with Tetrex (tetracycline phosphate complex).*

with the benefits of APC and Bristamin (phenyltoloxamine citrate). Traditional APC provides predictable relief of pain, fever and malaise in acute respiratory infections, while the phenyltoloxamine citrate—notable for its effective histamine-blocking action with minimal drowsiness—adds relief of watering eyes, rhinorrhea, congestion and "tight" chest symptoms.

References: 1. Roberts, C.E., Jr.; Perry, D.M.; Kuharic, H.A., and Kirby, W.M.M.: Arch. Int. Med. *107*:204 (Feb.) 1961. 2. Dowling, H.F.; Lepper, M.H., and Jackson, G.G.: Clin. Pharmacol. & Therap. *3*:564 (Sept.-Oct.) 1962. 3. Editorial: Antibiotics & Chemother. *11*:427 (July) 1961. 4. Baer, R.L., and Harber, L.C.: JAMA *192*:989 (June 14) 1965.

BRISTOL THERAPEUTIC SUMMARY. For complete information, consult Official Package Circular. *Indications:* Upper respiratory infections due to sensitive bacteria where concomitant symptomatic relief of fever, malaise and congestion is desired. *Contraindication:* A past history of hypersensitivity to one or more components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if discomfort occurs. No cases of photosensitivity have been reported with Tetrex (tetracycline phosphate complex). With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Antihistamines may cause drowsiness and patients should not perform tasks requiring mental alertness while taking this agent. Bacterial or mycotic superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for three months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis and allergic reactions may occur. *Usual Adult Dose:* Two capsules *q.i.d.* Continue therapy for at least 10 days in beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.

BRISTOL

BRISTOL LABORATORIES / Division of Bristol-Myers Co., Syracuse, New York

(Continued from Page 487)

ally occurring conditions in some women which have been noted as far back as medical experience extends."

In a non-related action, a thirteen-member panel, one of 30 making up the White House Conference on International Cooperation, proposed that the United States make $100 million available over the next three years to help foreign governments carry out family planning programs. The panel also urged that the Federal government set an international example by cooperating with state and local agencies to make birth control information services readily available in this country. Richard N. Gardner, professor of law at Columbia University, headed the panel.

Clinical Investigation—Government Style

A new drug may not be shipped across state borders for administration to a human until the sponsor of the drug (who may be the investigator) has filed a request for exemption for such use with the FDA . . . He must describe and identify the source of the drug and its manufacturer; he must describe previous animal studies with the drug to show that it is reasonably safe to initiate human studies; he must give evidence of his professional qualifications and his facilities for investigation. Finally, the investigator must certify that he will obtain consent from the persons receiving the drug except where this is not feasible or, in the investigator's best judgment, is contrary to the best interest of the subjects. The sponsor must also make progress reports at appropriate intervals, not exceeding a period of one year. He must promptly report any adverse effect which is reasonably regarded as due to the drug. He must maintain records for a period of two years after the drug has been approved or disapproved, or after his investigations have been discontinued. Joseph F. Sadusk, Jr., M. D. to Association of Military Surgeons.

Where New Drugs Come From?

Few, if any, new drugs or inventions have been commercially developed in countries which do not offer proper patent protection to the inventor. Of the new drugs introduced in the United States from 1941 to 1964, 369 came from the United States, 44 from Switzerland, 33 from Germany, and 28 from the United Kingdom. Equally significant is that 90 per cent of the 369 new drugs originating in the United States came from company laboratories. Editorial in *Michigan Medicine*, October 1965.

New Drug Score: USA 75, USSR Zero

How important is the patent system to the prevailing health care picture? Here are a few examples. In 48 years, Russia's government-owned pharmaceutical industry has not developed a single new and important drug. In 24 years, thanks in part to patent protection, the American pharmaceutical industry has come up with at least 75 new drug entities. Credit (and a considerable amount is due) must go to a competitive industry that thrives in a competitive economy — motivated by the rewards and contributions to knowledge that the nation's patent system has always guaranteed. Editorial in *GP*, November 1965.

Benefit vs Risk—That is the Ratio

Since there is no such thing as an absolutely safe drug, nor is there a drug that will prove effective in every patient in which it is used, the best we can achieve is a balance; that is, where potential benefit outweighs potential risk. It should be stressed that the benefit-risk ratio is not a constant. The scientist can afford a larger risk in a severe disease for which there is no completely effective therapy, for example, in leukemia, than he can in a relatively benign disorder. FDA Commissioner George P. Larrick in *Emory University Quarterly*, Summer 1965.

Announcing
EUTRON™

pargyline hydrochloride 25 mg. and methyclothiazide 5 mg.

for control of moderate to severe hypertension

Unique combination produces greater antihypertensive effect with lower doses

Eutron is the combination in a single tablet of 25 mg. Eutonyl (pargyline hydrochloride) and 5 mg. Enduron (methyclothiazide). This combination produces greater therapeutic effect than that of either component used alone. Side effects may be milder, too, as dosages are generally lower. The effective dosage is usually one tablet, once daily. Tablets are scored for greater dosage flexibility.



Each Eutron tablet contains two proven antihypertensives in the ratio shown to be most effective in most patients.

TM—TRADEMARK

New **EUTRON** extends your range of treatment in moderate to severe hypertension



A single product you can use even in the presence of congestive heart failure or edema

Eight out of 10 patients respond

In clinical trials, Eutron produced normotension or a significant reduction in blood pressure in eight out of 10 patients studied. The rationale for the product is this: Eutonyl used alone is a potent antihypertensive. Its antihypertensive action is markedly enhanced by Enduron, a potassium-sparing thiazide.[1,2,3] The combination (Eutron) thus produces greater antihypertensive effect with lower dosages of the Eutonyl component, and milder side effects may be seen.

512214

1. Torosdag, S., Schvartz, N., Fletcher, L., Fertig, H., Schwartz, M. S., Quan, R. F. B., and Bryant, J. M., Pargyline Hydrochloride as an Antihypertensive Agent With and Without A Thiazide, Am. J. Cardiol., 12:822, Dec., 1963.

2. Pollack, P. J., Pargyline Hydrochloride and Methyclothiazide Combined In The Treatment of Hypertension, Cur. Thera. Res., 7:10, Jan., 1965.

3. Bryant, J. M. et al., Antihypertensive Properties of Pargyline Hydrochloride, New Non-Hydrazine Monoamine Oxidase Inhibitor Compared with Sulphonamide Diuretics, J.A.M.A., 178; 406, Oct., 1961.



BP reductions in the recumbent and sitting positions often are nearly as great as in the standing. In clinical trials, the average *recumbent* BP reduction was 36/18 mm. Hg.



The average *standing* reduction in clinical trials was 45/22 mm. Hg. Thus the difference between the standing and recumbent readings was only 9/4 mm. Hg.

Significantly lowers blood pressure in all body positions; less likelihood of orthostatic hypotension

In clinical trials, the average reduction in standing blood pressure was 45/22 mm. Hg.; in the sitting position it was 48/20 mm. Hg.; and in the recumbent position, 36/18 mm. Hg.

Because Eutron effectively reduces blood pressure in all body positions, there is reduced likelihood of orthostatic symptoms or hypotension.

This was reflected in the relatively mild character of side effects seen in clinical trials (see below).

Smooth and gradual onset

Onset of antihypertensive action is usually quite smooth. Initial reduction of systolic and diastolic readings is usually seen within a week — maximum reduction in seven to ten days.



Less troublesome side effects may be seen; frequent improvement in "sense of well-being"

Fewer than 1% of patients studied discontinued Eutron therapy because of side effects. This is due in part to the relatively low dosage needed with the combination. Usual recommended dose is one tablet daily—that is, 25 mg. Eutonyl with 5 mg. Enduron. *This is about half the usual therapeutic dose of Eutonyl given alone.* As a consequence side effects may be milder. And, as with Eutonyl given alone, the patient may well note an increased sense of well being. This is in distinct contrast to most other antihypertensive therapy.

ABBOTT

Prescribing information for **EUTRON**

INDICATIONS: Eutron (pargyline hydrochloride and methyclothiazide) is indicated in the treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. It is not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

CONTRAINDICATIONS: Eutron is contraindicated in patients with pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained it cannot be recommended for use in patients with malignant hypertension, children (under 12 years of age), or pregnant patients.

The concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. A drug-free interval of two weeks should separate therapy and use of these agents.

WARNINGS: Pargyline hydrochloride is a monoamine oxidase inhibitor. Patients should be warned against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When it is necessary to administer alcohol, narcotics (notably meperidine), antihistamines, anesthetics, barbiturates and other hypnotics, sedatives, tranquilizers, or caffeine, these agents can be used cautiously at a dosage of ¼ to ⅕ the usual amount. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Patients should be warned about the possibility of postural orthostatic hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Potassium depletion is unlikely at the recommended dosage, but if it occurs, adjust dosage or withdraw or provide added natural food sources of potassium; potassium tablets should be avoided wherever possible, as bleeding or obstructive ulceration of the small bowel has been associated with their use; potassium levels should be especially watched if the patient is on digitalis or steroids, or if hepatic coma is impending.

PRECAUTIONS: When determining the antihypertensive effect of Eutron, blood pressure should be measured while the patient is *standing*. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Pargyline has not been shown to cause damage to body organs or systems. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. The drug should be used with caution in patients with liver dysfunction. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

Elevated blood urea nitrogen, serum uric acid or blood sugar are possibilities attributable to the methyclothiazide in Eutron. Methyclothiazide may also reduce arterial response to pressor amines. Blood dyscrasias, including thrombocytopemia with purpura, agranulocytosis and aplastic anemia, have been seen with thiazide drugs.

SIDE EFFECTS: The use of pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve. Nocturia has been observed with the combination. If side effects persist, despite symptomatic therapy or reduction of the dose, discontinue the drug.

ABBOTT

512214

COMMITTEE STATEMENT

American Academy of Pediatrics

COMMITTEE ON CONTROL OF INFECTIOUS DISEASES

SUPPLEMENTARY STATEMENT ON ORAL POLIOVIRUS VACCINES

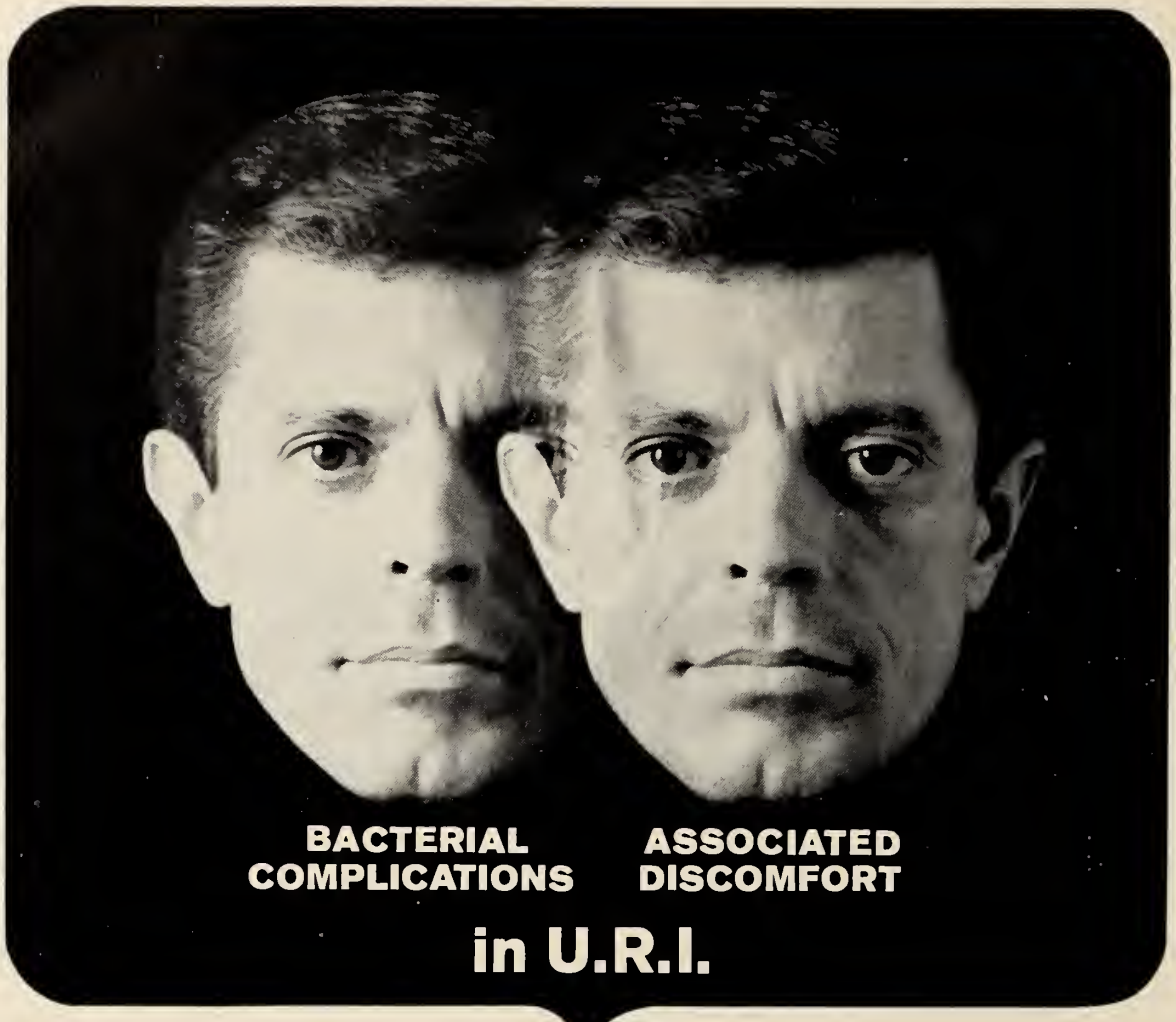
(In the light of new advances, the following supplementary statement to the 1964 Red Book was approved by the Committee at a workshop meeting in New York City Oct. 25, 1964.)

In July 1964, a Special Advisory Committee on Oral Poliomyelitis Vaccines to the Surgeon General, U. S. P. H. S., met to discuss surveillance of poliomyelitis in the United States with particular reference to possible oral vaccine associated cases. The report of the Committee was published in *J. A. M. A.* (190: 49-51, October 5, 1964) together with minority comments on the report by Dr. A. B. Sabin (Pages 52-55).

The Committee noted that since 1961 approximately 100 million doses of each of the three types of oral poliovirus vaccine have been given in the United States. Surveillance by the Epidemiology Branch of the U. S. Public Health Service Communicable Disease Center indicates that a total of 87 cases of paralytic disease following within 30 days of oral vaccination have been reported (Henderson, et al., *J. A. M. A.* 190: 41, October 5, 1964). On the basis of careful sifting of the available epidemiological, clinical, and laboratory data, 57 of the 87 cases were judged "compatible" with vaccine association, although it was recognized by the Special Advisory Committee that in no single instance was it possible to prove that a given case could be definitely attributed to the vaccine. Nevertheless, certain unusual features of the cases as a group led to the conclusion that at least some of those labelled "compatible" were caused by the vaccine. These features include: 1) the preponderance of cases following Type III vaccine while virtually none followed Type II; 2) the predominance of cases in adults, who are known to be more susceptible to the paralytic consequences of infection than are children; 3) and the virtual absence of contact cases.

Assessment of the actual risk revealed it to be extremely small: for Type I, 1 per 6.25 million; for Type II, 1 per 50 million; and for Type III, 1 per 2.5 million. From all available evidence it was concluded that "the risk is highest for Type III; the evidence of risk is less definite for Type I vaccine. For Type II vaccine the rate is so low as to suggest absence of risk."

(Continued on Page 539)



BRING THE TREATMENT TOGETHER IN A SINGLE PRESCRIPTION

ACHROCIDIN®

Tetracycline HCl-Antihistamine-Analgesic Compound

Each tablet contains:			
ACHROMYCIN® Tetracycline HCl	125 mg	Caffeine	30 mg
Acetophenetidin (Phenacetin)	120 mg	Salicylamide	150 mg
		Chlorothen Citrate	25 mg

Effective in controlling complicating tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects include drowsiness, slight gastric distress, anorexia, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation), photodynamic reaction to sunlight and increased intracranial pressure (in young infants). Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals. Patient should avoid direct exposure to artificial or natural sunlight; and should not drive a car or operate machinery while on drug. Reduce dosage in impaired renal function. Stop drug immediately at the first sign of adverse reaction.

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On the basis of these findings, the Special Advisory Committee recommended "continuation and intensification of the poliomyelitis immunization program throughout the nation, although with some changes in emphasis." These changes relate primarily to the age groups to be vaccinated, suggested alterations in schedules of administration and to the desirability of increased vigor in organizing and carrying out on-going immunization programs of infants and young children. The importance of such on-going programs of immunization of infants in the first year of life was reemphasized, and it was urged that all communities which have not already organized such programs do so promptly. Furthermore, any communities which have not yet conducted mass immunization programs were encouraged to do so during the fall and winter of 1964-65. The target of such community-wide programs should be the immunization of as close as possible to 100 per cent of pre-school children: such children constitute the bulk of susceptibles in any community, and are in turn the most effective spreaders of wild polioviruses should such be introduced into the area. Because the theoretical very slight risk attending oral vaccination is chiefly to adults, it was recommended that the age limit for vaccination in community programs be approximately 18 years. However, vaccination of young adults was recommended under special circumstances of increased exposure such as epidemics, entry into military service, or travel to foreign countries.

REVISED RED BOOK RECOMMENDATIONS FOR THE USE OF ORAL POLIOVIRUS VACCINE, NOVEMBER 1964

On the basis of the Report of the Surgeon General's Special Advisory Committee taken in conjunction with all other available pertinent data, the use of oral poliovirus vaccine (OPV) continues to be the optimum immunization procedure for the prevention of paralytic poliomyelitis in children. While inactivated vaccine has also proved effective, evaluation of the virtues and limitations of killed and live poliovaccines reveals a clear-cut superiority of the OPV from the point of view of ease of administration, immunogenic effect, protective capacity, and potential for the eradication of poliomyelitis. It is therefore the vaccine of choice for community-wide vaccination programs and for routine immunization in infancy and childhood.

Contraindications

There are no contraindications to oral poliovirus vaccine for infants and children. In the past it has been recommended that the three live virus vaccines — oral poliovirus, measles, and vaccinia — be given separately at intervals of at least one month. There is now evidence (*S. A. Med. J.* 37: 513-515-1963) that safe and satisfactory immunization with vaccinia and oral poliovirus vaccine may be achieved when the two vaccines are given at the same time, but until further data are available measles and oral poliovirus vaccine should continue to be given separately. In order to avoid chance erroneous implication of the oral poliovaccine virus in unrelated subsequent illness, and to avoid interference by wild enteroviruses, community programs with OPV should not be held in the natural poliomyelitis season. An exception to this general rule obtains only when epidemic poliomyelitis appears in a community. The latter constitutes an indication for an emergency community-wide immunization program with OPV using the virus type demonstrated to be causing the epidemic. Elective T and A may be scheduled at any time of year in the absence of a poliomyelitis outbreak in communities that have conducted a mass immunization program and in patients who have received OPV.

Community-wide Programs

All communities which have not thus far carried out mass vaccination programs should do so in the fall and winter of 1964-65. The guidelines previously recommended should be followed with the exception that even greater emphasis should be placed on the pre-school age group and the suggested cut-off age should be approximately 18 years. The latter recommendation is based on changes in the national incidence of poliomyelitis brought about as a result of successful immunization programs, as follows: 1) in the U. S. the present risk to adults of naturally occurring poliomyelitis has been reduced to such an extremely low level that continued immunization of this age group is no longer necessary except under special circumstances; and 2) continued immunization of infants and pre-school children, the chief spreaders of wild polioviruses, protects susceptible adults indirectly by preventing virus circulation and therefore preventing exposure to infection.

Suggested Schedules of Administration

Community-wide campaigns. Several schedules are satisfactory. These include in the order of preference:

1) Monovalent vaccines, the three types to be given at approximately six-to-eight-week intervals. The order in which they are given is not crucial, but the optimum schedule is Type I, Type III, Type II. The advantage of beginning with Type I is that it is the most important one in terms of paralytic disease; since the number of vaccinees receiving the first dose in community campaigns is always greater than the number reporting for subsequent doses, it is desirable that Type I be given first, followed by Types III and II at approximately six-to-eight-week intervals. Giving Type II virus first is not recommended for children. This has the theoretical advantage that Type II may provide cross protection against the other two types. However, the evidence for this is not impressive. It has the disadvantage that Type II virus may interfere with subsequent Type I infection and thereby decrease the percentage of recipients who develop immunity to Type I virus.

2) Monovalent Type I vaccine, followed after six-to-eight-weeks by a dose of Types II and III given simultaneously on the same sugar lump or in the same spoon. This has the advantage of complete coverage for Type I and the simplicity of a two-dose schedule.

3) Trivalent vaccine twice, at six-to-eight-week intervals. While this schedule is satisfactory for school age and older children, an additional third dose for infants and pre-school children provides more reliable immunization against Type I.

Primary immunization of infants. Either monovalent or trivalent vaccines may be used. In either case, the schedule may be integrated with DTP immunizations with the first dose to be given at approximately two months of age. If monovalent vaccines are used, they should be given in the order Type I, Type III, Type II at six-to-eight-week intervals. If trivalent vaccine is given *three doses* are recommended. Whether monovalent or trivalent is used in the primary course, a fourth dose, consisting of trivalent vaccine, should be given to infants at 12 to 15 months of age.

Primary immunization of other pre-school children. The procedure may conform to that outlined for infants with the exception that the fourth dose may be omitted; or the primary course may consist of 2 doses at six-to-eight-week intervals followed by a third dose approximately one year later.

(Continued on Page 542)



On Stelazine® brand of trifluoperazine she's calm and alert

When a tranquilizer is needed, 'Stelazine' can regulate the level of anxiety so that the patient is unlikely to overreact to stress but is not tranquilized into psychic inertia. Patients on 'Stelazine' often experience a sense of mental alertness and, because they feel so much better, are more interested in their normal activities.

Contraindicated in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects,* usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems.

Before prescribing, see SK&F product Prescribing Information.

Photograph professionally posed.

SK&F

Smith Kline & French Laboratories

(Continued from Page 540)

Primary immunization of all others up to and through eighteen years of age. If monovalent vaccines are used, they should be given in the order Type I, Type III, Type II. If trivalent vaccine is given, two doses six-to-eight-weeks apart are satisfactory.

Immunization of all children on entering school. A single dose of trivalent vaccine is recommended on entrance to school for all children who have previously been immunized with OPV. This is designed to fill in any antibody gaps resulting from the occasional failure to achieve a vaccine take with one or another type during the primary course of immunization. If the child has never received oral vaccine, a full course using monovalent or trivalent vaccine should be given.

Procedure for partially immunized children. Oral vaccine may be ineffective if the complete series is not given. Persons who have had a partial or complete series of inactivated vaccine when given OPV should receive a complete series of OPV vaccine virus in either monovalent or trivalent form, as outlined above. After the full series of OPV has been completed, no further injections of inactivated vaccine need be given.

Immunization in the presence of an epidemic. The virus type responsible should be identified and the corresponding monovalent vaccine offered on a community-wide basis as quickly as possible. All age groups from two months up should be included.

Committee on the Control of Infectious Diseases

Lewis L. Coriell, M. D., Chairman; Floyd W. Denny, Jr., M. D.; Dorothy Horstmann, M. D.; David Karzon, M. D.; George A. McNaughton, M. D.; Frederick Robbins, M. D.; Sarah H. Wood Sell, M. D.; Margaret H. D. Smith, M. D.; Henry B. Strenge, M. D.; Franklin H. Top, M. D.; Dwain N. Walcher, M. D.; Robert Ward, M. D.; Clarence H. Webb, M. D., and Thomas H. Weller, M. D.



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Peachtree Hospital, located in Atlanta, Georgia, is a complete psychiatric, alcoholic and drug addiction treatment facility accredited by the Joint Commission on Accreditation of Hospitals ☐ The hospital has 65 beds, 47 of which are devoted to the care of psychiatric patients and 18 of which, in a separate area, are for patients with acute cases of chronic alcoholism or drug addiction ☐ Treatment procedures include psychotherapy, electroconvulsive shock therapy, subinsulin coma and chemotherapy ☐ *We will be pleased to provide further information upon request.*

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The Alabama Chronic Respiratory Disease Project

by Don S. Tysinger, Jr., M. D.

For the past four years the Alabama Tuberculosis Association with the assistance of its county associations, state and county health departments, and the Medical College of Alabama has been conducting a research program in the field of chronic respiratory diseases, particularly emphysema. These studies have been financed through a research contract with the Division of Air Pollution, Public Health Service.

During this period much has been learned of the tremendous extent of the problem these chronic respiratory diseases impose on the people of Alabama. Also, much has been learned of the techniques of early case detection, patient evaluation, and physical and vocational rehabilitation of the individuals involved.

The Association now, under the direction of the Alabama Thoracic Society, its medical section, is organizing a further development of this effort under a service grant from the Chronic Respiratory Disease Program of the Public Health Service. Objectives of this new program include not only case detection, but assistance to the physicians of Alabama in the evaluation and treatment of these chronic respiratory diseases.

The project will operate in four phases. Upon request of the County Medical Society expressed through the county health officer and the county tuberculosis association, a preliminary screening or "survey" vehicle will be made available for scheduling in a particular county. The general public will be invited to receive a chest X-ray and a pulmonary function test consisting in a recording of a flow volume loop. Pulmonary measurements will be read by computer and these results together with the chest X-ray interpretation and answers provided by the individual on a simple, self administered sociomedical history questionnaire, will form the basis of the preliminary classification of patients.

All positive reports from the screening program will be sent to the personal physician named by the patient. The latter will receive a statement to this effect and a notification that his physician may consider him in need of further examination. Detail technical reports will not of course, be sent to the patient.

In the second phase of the project operation, a vehicle containing a very complete mobile pulmonary function laboratory will be sent to the community concerned. Physicians will be notified that if they desire, they may refer individuals to this unit for complete laboratory testing and evaluation. These patients may be those picked up in the preliminary screening or they may be other individuals known to the local physician concerned. No patient will be examined without a referral slip from a local physician. Physicians referring patients will be asked to send with the patient a simple form containing basic information needed by personnel of the program. Such information will include notation of all drugs currently being administered, allergies, previous diagnoses, and if the patient can afford it, an electrocardiogram, hemoglobin and hematocrit and BUN.

All results will be reported to the referring

physician, together with an evaluation of the patient and a suggested treatment program to be followed. Again it should be emphasized that no technical reports will be sent directly to any patient.

At the end of a three-months period (approximately) a mobile pulmonary function laboratory will return to the community for a re-study of patients referred, to check progress of treatment and suggest any modifications in therapy which may appear advisable. It is hoped that repeated visits of the unit at about this interval may be possible.

As may be seen, the broad function of this entire program is to assist the medical profession of Alabama in this vast and growing problem of chronic pulmonary disease. With the exception of the preliminary screen which will operate in a similar manner to the chest X-ray surveys of long standing proven merit, all services will be rendered through the medical profession and only as individual physicians may request.

Services available will include as a third phase, assistance to individual patients in provision of drugs, breathing instruction and exercises, the IPPB therapy where indicated, but only for indigent patients and at the request of individual physicians referring such patients.

The fourth phase of the project will consist in vocational rehabilitation activities in cooperation with the Vocational Rehabilitation Service, Alabama State Department of Education.

Every effort will be made to make the program of educational benefit to the profession. The chief clinician and others on the project staff will be available for meetings with county medical societies; physicians referring patients will be given a syllabus specifically designed and written for the project on pulmonary function testing, pulmonary physiology, the symptomatic approach to chronic lung disease, and the evaluation of pulmonary function studies.

It is very important that from the beginning it be thoroughly understood that all concerned except to learn from the program. Those on the staff are very desirous of receiving all suggestions, ideas, opinions by participating physicians on which activities they think may be changed and improved, etc.

This program promises to be one of the largest studies ever undertaken in the treatment of chronic pulmonary disease. With the cooperation of all physicians it can be of tremendous and basic importance to the furtherance of scientific knowledge in this admittedly difficult field. For this reason, it is our sincere hope that physicians participating will accept recommendations for therapy of patients involved in order that at the end of the project, evaluation of the effectiveness of treatment and the degree of rehabilitation possible of such individuals may be secured. If this is done, an almost unlimited source of information concerning the effectiveness of pulmonary function studies, the effectiveness of various treatment regimens, and the true incidence and prevalence of the various chronic respiratory diseases will be forthcoming. It is our belief that the whole nation will owe a debt of gratitude for your cooperation in this huge endeavor to be carried out in the state of Alabama, truly a pilot project in the fight against the nation's second largest cause of premature retirement and a rapidly increasing cause of death.

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NEWS BRIEFS

The 18th International Tuberculosis Congress was held in Munich during October. It was reported that about three million deaths are attributed to TB annually and that some fifteen million people living in newly-emerging nations are capable of transmitting tuberculosis.

* * *

A five-year research and demonstration program to give intensive training to severely retarded girls has been announced at the Parsons State Hospital and Training Center in Parsons, Kansas. Grants totaling $475,000 over a five-year period have been made by the U. S. Public Health Service through the University of Kansas Bureau of Child Research.

* * *

The new president of the American Heart Association is Helen B. Taussig, M. D., the first woman and the first pediatrician to hold this post in the Association's 41-year history. She is Professor Emeritus of Pediatrics at Johns Hopkins University.

* * *

Proceedings of an annual conference of the Surgeon General of the Public Health Service with State Hill-Burton Hospital Construction Authorities is now available. *Opportunities for Planning and Constructing Medical, Mental Retardation, and Other Health Facilities* may be obtained from the U. S. Government Printing Office, Washington, D. C. 20402, for forty cents a copy.

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Contraindications: Contraindicated in individuals who have shown hypersensitivity to any of its components. Not recommended for prophylaxis or in the management of infectious processes which may require more than 10 days of continuous therapy. If clinical judgement dictates therapy for longer periods, serial monitoring of liver function is recommended. Not recommended for subjects who have shown abnormal liver function tests, or hepatotoxic reactions to triacetyloleandomycin.

Precautions and Adverse Reactions: Triacetyloleandomycin, administered to adults in daily oral doses of 1.0 gm. for 10 or more days, may produce hepatic dysfunction and jaundice. Adults requiring 3 gm. of Signemycin initially should have liver function followed carefully and the dosage should be reduced as promptly as possible to the usual recommended range of 1.0 to 2.0 gm. per day. Present clinical experience indicates that the observed changes in liver function are reversible after discontinuation of the drug.

Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacetyloleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.

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THE HEALTH CAREERS COUNCIL OF ALABAMA

ITS ORGANIZATION AND PROGRAM

GEORGE F. SCOFIELD, M. D.

Since World War II there has been an unparalleled growth of health facilities in Alabama. In the period from 1953 to 1963 there has been a ten per cent increase in hospitals with the total hospital beds increasing by approximately one-third. Unfortunately, there has not been a similar increase in the trained health service personnel. Not only have the health facilities and the people requiring health service increased but the health services themselves have become far more complex. Technologists are performing routine procedures today that were only in the minds of research people several years ago.

Because of the acute and chronic shortage of health personnel in Alabama, three professional groups, Council of Directors of Nursing, Alabama Hospital Association, and the Medical Association of the State of Alabama initiated a study of the problem of the shortage of health personnel in this state in 1963. An outgrowth of this study led to establishment of the Health Careers Council of Alabama in February, 1965. The avowed purpose of the Health Careers Council is to expand and coordinate activities in the areas of education about health career's opportunities and recruitment of people into health careers and health work.

The Health Careers Council is an established agency of the Alabama Hospital Association Education and Research Foundation, Inc., and receives its principal financial support from the members of the Alabama Hospital Association through this foundation. Financial support has been solicited and obtained from other groups interested in health education as well as from industry and individuals. The Council is composed of nine members—three hospital administrators, three physicians (one of which is a pathologist), a public educator, a nurse, and a member from the general public.

The Health Careers Council of Alabama was very fortunate in securing the services of Miss B. Parnell Langston as Director. Miss Langston was formerly an assistant administrator of the University Hospital, Birmingham. The Council has an established office at 901 South 18th Street, Birmingham, Alabama, and in addition to Miss Langston has a full-time office secretary. The activities of the Council have been in the areas of recruitment and coordination. The major work has been done through high school guidance counselors and in providing literature to schools and other interested groups.

During the nine months that the program has been in operation, the following specific activities have been accomplished:

1. Has reprinted and distributed the very fine booklet **Health Careers In Alabama**

(Continued on Page 553)

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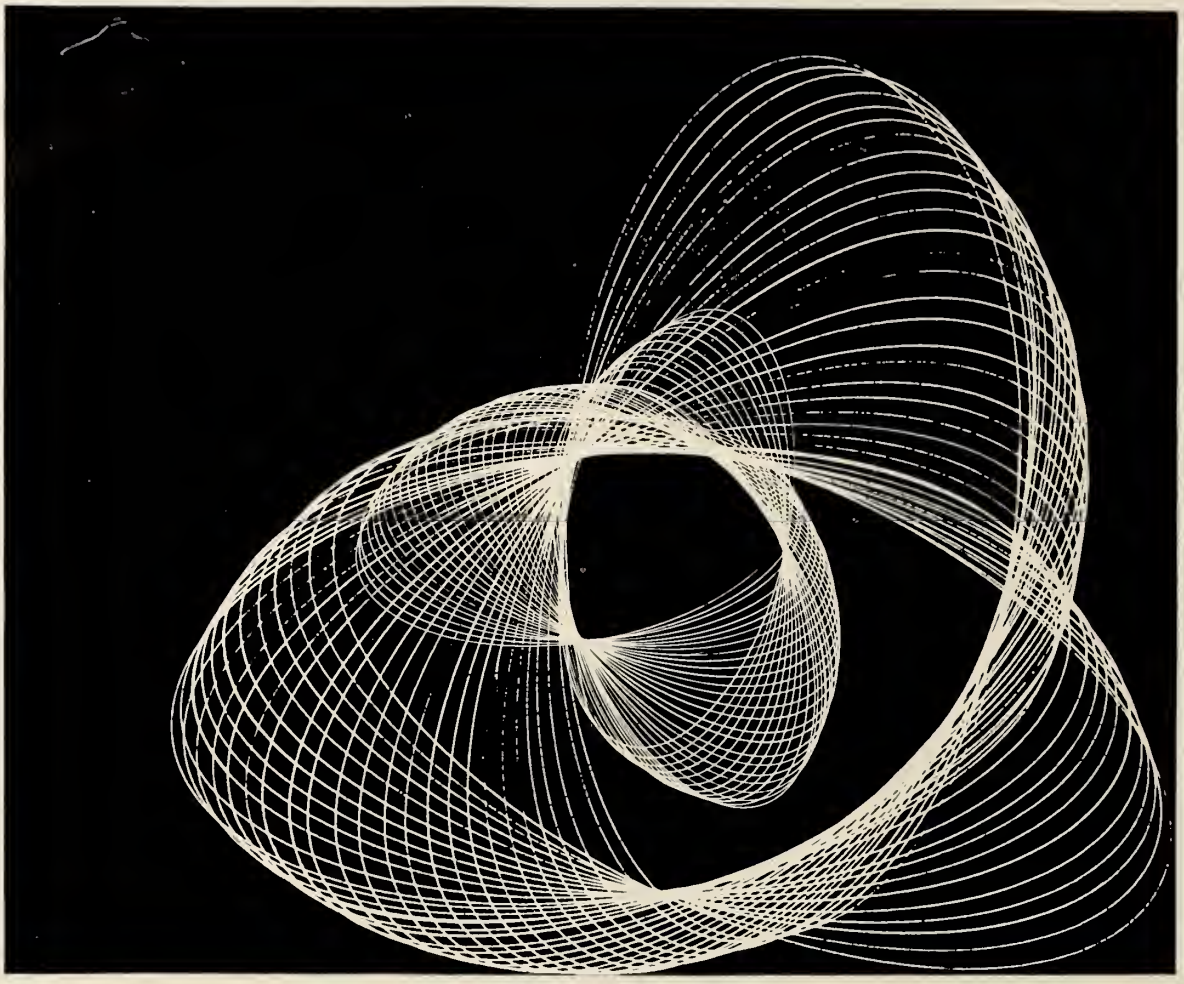
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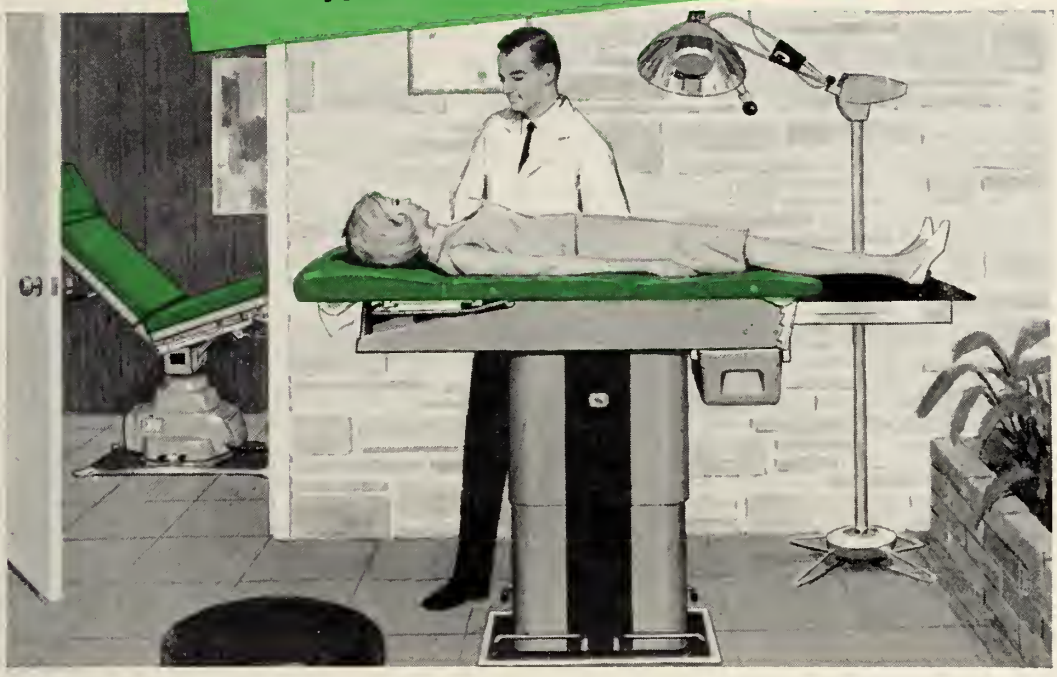
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(Continued from Page 548

which was initially developed by the Auxiliary of the Medical Association of the State of Alabama.

2. Stocking and maintaining current information on career opportunities in the health field to answer inquiries from high school students, parents, guidance counselors, and other appropriate individuals.

3. Providing an information service to guidance counselors.

4. Information sessions in health careers at civic meetings, church meetings, and other professional groups.

5. Development of health career material and statewide distribution of that material to create an awareness of the public regarding the need for additional health personnel.

6. Some 3000 student contacts have been made all of which were provided with information regarding their field of interest.

7. Several health career exhibits have been held including exhibits at the Spring and Fall Fairs.

8. Newspaper publicity—a series of articles on health careers was recently published in the Birmingham News and other daily newspapers in Alabama are being encouraged to use a similar series.

The Council is interested in the recruitment of personnel in all areas of the health field. Everyone is aware of the chronic shortage of trained medical technologists. The recruitment of qualified students into this profession is one of the goals of the Health Careers Council. It is the intention of the Council to serve as a coordinating agent for activities in recruitment and to more or less serve as a clearing house of information. The Council has no intention or desire to discourage the recruitment activities of any group and to the contrary would like to encourage these activities, and where possible to augment them. This is particularly true in the field of Medical Technology, where such an outstanding job of recruitment has been done by the Alabama State Society of Medical Technologists. The technologist's recruitment chairmen will find a very willing and able ally in Miss Langston and it is hoped that the facilities of the Council will be utilized to the fullest.

The next immediate objective of the Health Careers Council is to develop a committee in each county to provide a local resource and a follow up mechanism to students interested in health careers in each county area. A medical technologist will be asked to serve on each of these committees in the individual counties. It is anticipated that these committees will be constituted and functioning within the next few months.

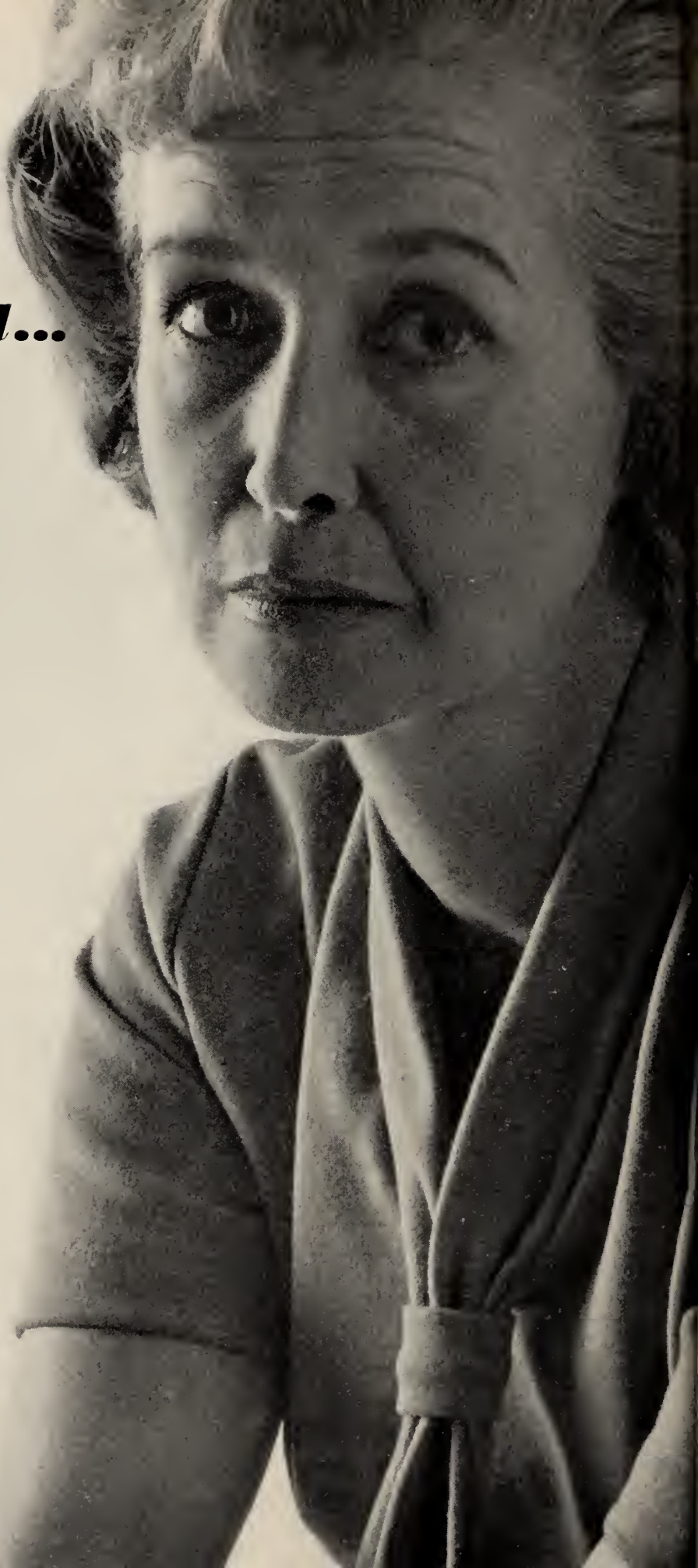
Reprinted from the *Alabama Journal of Medical Technology*, December, 1965.

ATTENDING COMMITTEE MEETINGS

Did you accept an appointment to a Medical Society committee because you only wanted to see your name in print? Do you begrudge an hour or two, perhaps three or four times a year, to serve on the committee to which you were appointed? When a committee chairman calls a meeting with invited guests to discuss current problems, it is disheartening to him to find very few committee members present at the meeting. The chairman, alone, cannot do it all.

The entire structure of our Medical Society depends upon the activities of the various committees. We realize that the demands upon the members of our Society are great but to build and maintain a strong organization, we ask you to give a few hours of your time and energy to the committee of which you are a member. This will not only be a service to yourself, but to your committee and to the Medical Society as a whole.

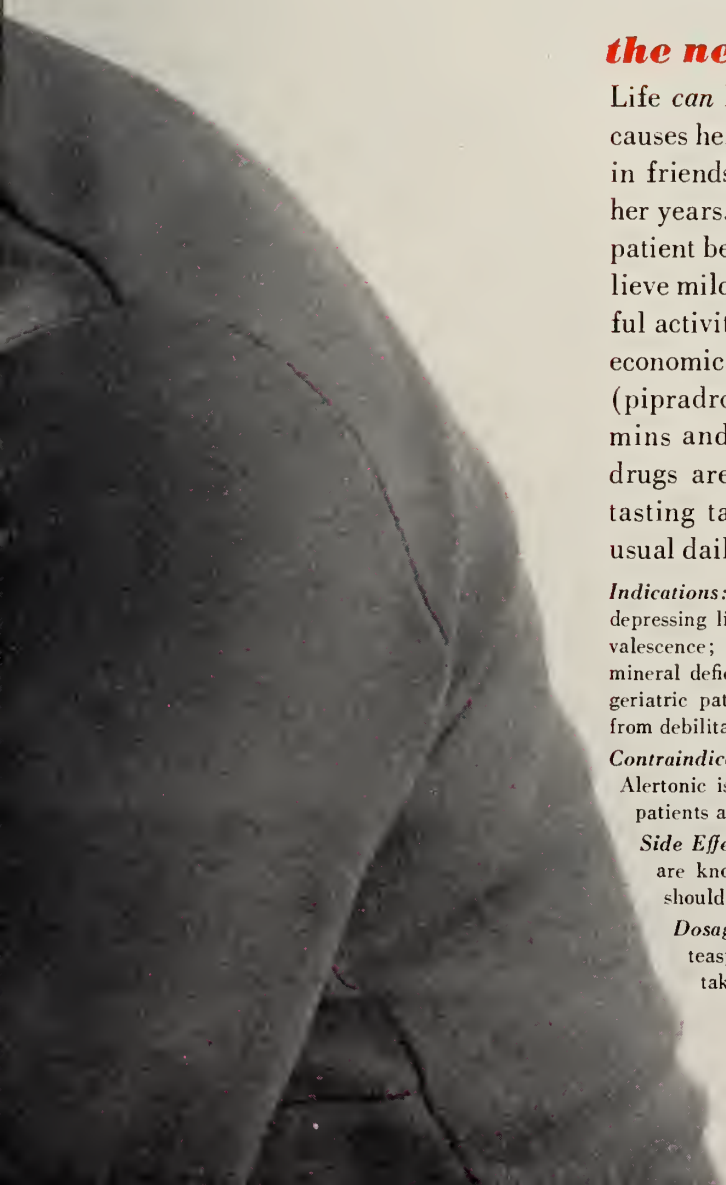
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Contraindications: As with other drugs with CNS-stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive-compulsive states.

Side Effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

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COMPOSITION: Imteron (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental Iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imteron (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

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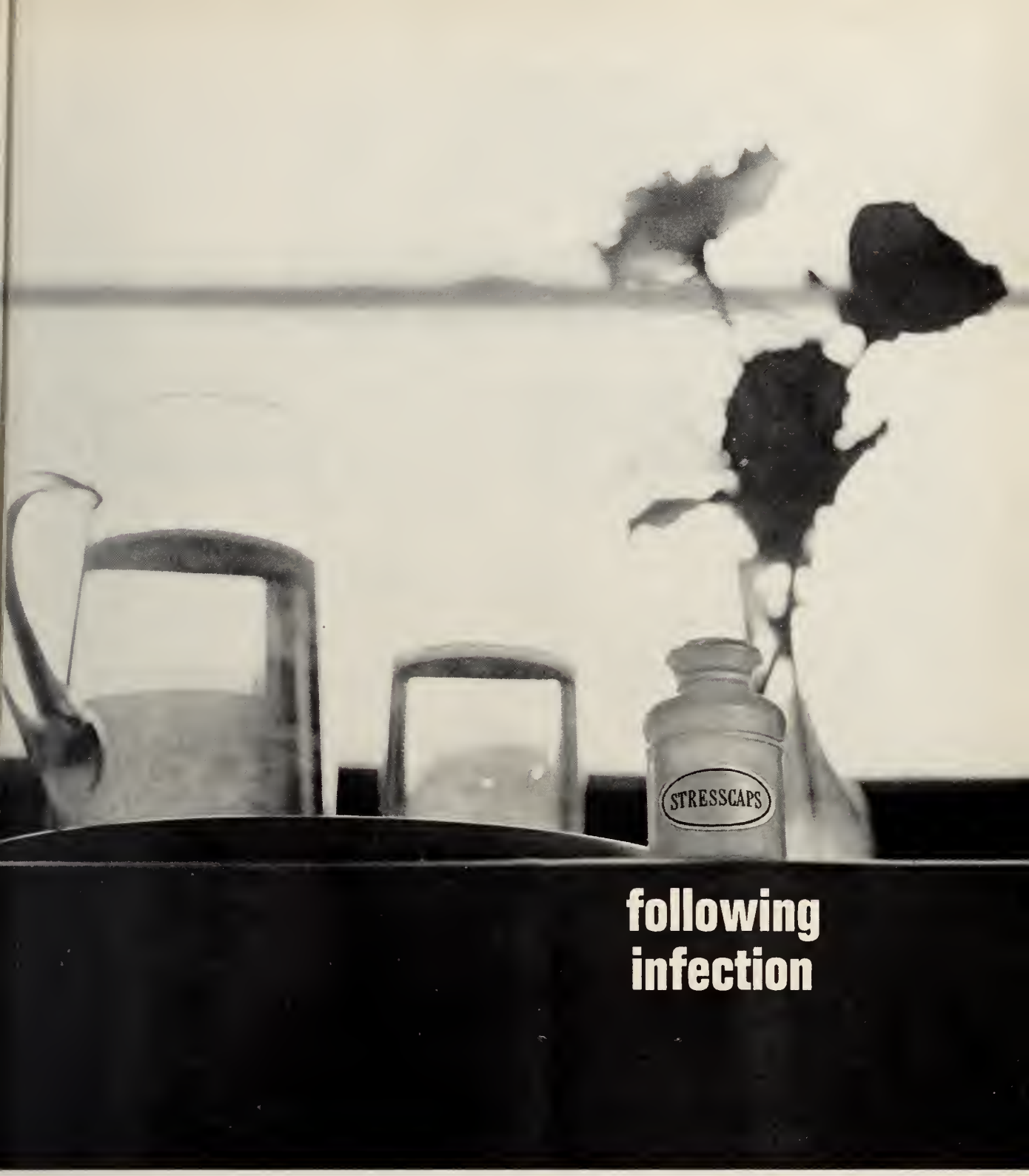
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TRAFFIC SAFETY STARTS WITH THE YOUNGSTERS

Teaching children how to walk to school **safely** is as important as teaching them the three Rs, says the Automotive Safety Foundation of Washington, D. C.

It's never too early to teach children good safety habits, and parents must bear the major responsibility. Teachers and school authorities share this responsibility for pupils in the lowest grades, particularly in the neighborhood of the school.

Ten basic principles that parents and school officials should insist upon are set forth in a "Guide to a School Pedestrian Safety Program" published recently by the Foundation. The booklet stresses these points:

1. Traffic safety education should be provided in the classroom.

2. Every elementary school pupil should be taught to choose the safest route between his home and school, and to follow this same route every day.

3. Parents are obligated to understand traffic regulations and to make sure their children understand them. Parents exert the most influence in developing their children as safe and self-reliant pedestrians.

4. Uniformity is important in traffic control. Traffic signs, signals, pavement markings, and regulations should conform to nationally accepted standards.

5. Signals and other traffic controls should be based upon engineering studies of the traffic flow at principal school crossings.

6. Children should be protected at main crossings by school safety patrols and/or adult guards in uniform, and possibly signal lights.

7. School bus routes should make a maximum penetration into the residential areas they serve. Pick-up points should be located on minor streets, not on highways.

8. Every city, town, and village should have a Central School Traffic Safety Committee. Each school should have a similar citizens' committee.

9. Parent-teacher associations and other civic organizations should press for improved safety measures.

10. Much of the potential hazard to pupils can be eliminated if pedestrian safety is considered when the school site is chosen.

Eight national organizations joined in preparing the safety guide, which is intended to aid municipal and school officials, the police, city planners, and real estate developers. It's illustrated with sketches and color photos. The organizations compiled a list of policies and practices that have proved effective in many different cities and towns. Thus one community can benefit from the experience of another.

"Learning to live in today's traffic environment is a serious business," the booklet starts off. "Children face a variety of complex traffic situations every day. Where should they walk along streets without sidewalks? How should they cross a street safely?"

The Automotive Safety Foundation recommends the formation of a Central School Traffic Safety Committee in every community to coordinate the activities of officials and organizations interested in safety. This should be limited to five or six leaders in the local school board, police department, parent-teacher association, safety council, and traffic engineer's office.

One of the Central Committee's most important responsibilities is to promote pedes-

trian route planning for each elementary school pupil.

The child, with guidance from his teacher, draws a simple map showing the school location, existing traffic controls (crossing guards, traffic lights or signs), and the "safe route" from home to school.

The completed map is taken home by the child for review with his parents. One of the parents should walk the route with his child and instruct him in the use of the map.

"Children should be discouraged from crossing major highways at many different intersections," the booklet points out. "Instead, wherever possible, routes should converge at a single crossing point, preferably a location already equipped with traffic controls. This may require some children to walk longer distances. Nevertheless, it is safer for them to cross at a single well controlled intersection than to use scattered crossing points."

Streets without sidewalks should be used only if no safer path is available, and streets with numerous alleys and driveways should be avoided. At some intersections parking may have to be curtailed to permit better visibility.

School crossing locations have varying degrees of hazard which can be measured by comparing the frequency of safe gaps in traffic at each location. Children can cross safely at many locations marked only by SCHOOL CROSSING signs. Busier spots may require school safety patrols, adult crossing guards or policemen, traffic signals, or even an overpass.

Through the Parent-Teacher Association, parents can take an active part in campaigning for good safety measures, including school safety patrols composed of older schoolboys.

School safety patrols instruct, direct, and control pupils at street crossings, but they do not direct vehicular traffic. Adult guards —uniformed men or women—may be used at busier crossings, perhaps in combination with school patrols.

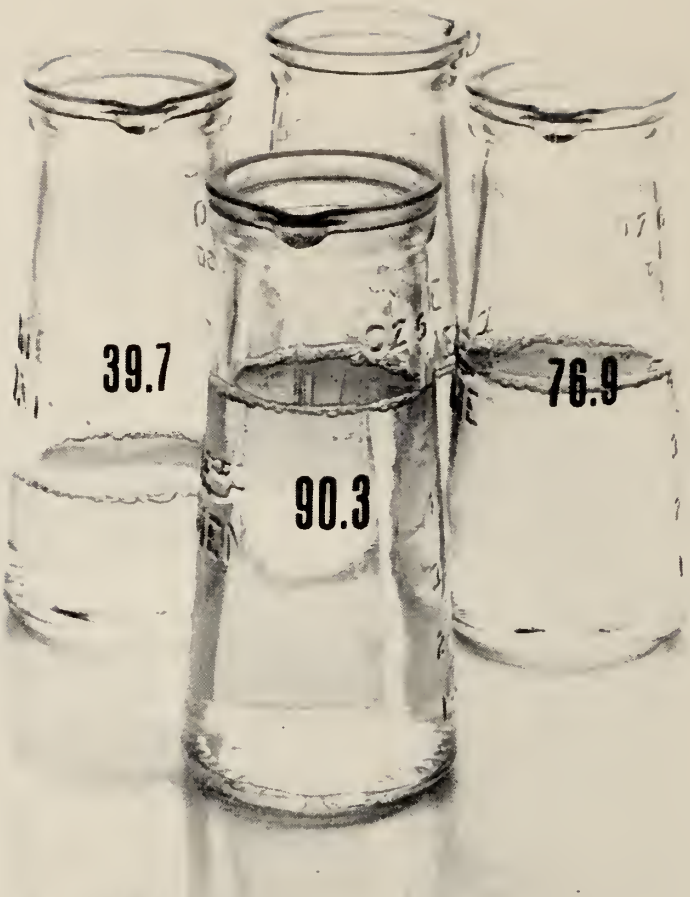
Although they are authorized to stop cars, the adult guards do not direct traffic in the usual police regulatory sense. In the control of traffic they pick opportune times to create a safe gap.

"Adult crossing guards do not need the power of arrest," says the booklet. "They should report reckless drivers, however. The thing they need most is to understand children."

There's still need for a pedestrian safety program even if most of the pupils are transported to school by bus, the booklet points out. In the country, many youngsters must walk along roads with no sidewalks to get to the bus stop.

"Much of the potential hazard can be eliminated if pedestrian safety is considered at the time the school site is chosen. Ideally, a school should be located where there is no need for children to cross a major street to reach it. Short of this, the crossings of busy streets should be kept to a minimum, and should be near the school for efficient control. The site must be large enough to provide suitable, safe areas for loading, unloading and parking."

In publishing the booklet, the Automotive Safety Foundation said it was intended for city or town planners and for real estate developers, as well as for school and municipal officials. Large new housing developments, for example, should have well chosen areas reserved for schools when the plots are laid out.



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METAHYDRIN®

(trichlormethiazide)

To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin® (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

to help relieve pain
in common
anorectal disorders

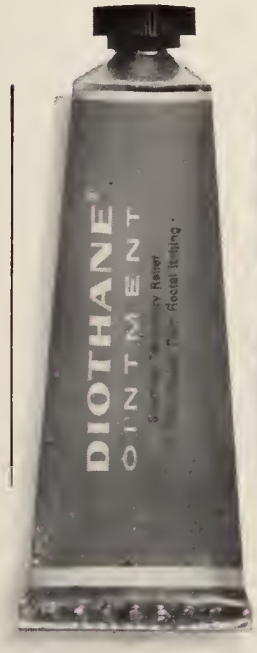
"non-caine" Diothane®

Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form...both are now available.

THANE OINTMENT

POSITION:
rodon 1.0%; oxyquinoline
ate 0.1% in a special oint-
base.

CATIONS:
des temporary palliation of
hat may result from hemor-
ectomy and from common
ctal disorders such as hemor-
s, anal fissures, pruritus ani.





DIOTHANE SUPPOSITORIES

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215/Weston, Ontario



around the state

CALHOUN COUNTY MEDICAL SOCIETY ELECTS NEW OFFICERS

Dr. Warren G. Sarrell, Anniston internist, has been selected to lead the Calhoun County Medical Society for 1966.

Dr. Sarrell was elected to succeed Dr. Gerald G. Woodruff, Jr., Anniston pediatrician, as president of the society at its recent December meeting at Stringfellow Hospital.

Dr. Woodruff was chosen to fill a five-year term on the Board of Censors vacated by Dr. Sam F. Crabtree. The Board, made up of five doctors with alternating five-year terms, governs the Calhoun County Board of Health.

Dr. Gaston McGinnis was elected by county doctors to serve as vice-president. He is a surgeon.

Dr. Fred C. Ballard, obstetrician, was elected secretary and Dr. R. L. Lucas was re-elected treasurer.

COLBERT COUNTY MEDICAL SOCIETY NAMES NEW OFFICERS

Dr. Winston Williams, Sheffield physician, has been named president of the Colbert County Medical Society, replacing Dr. Howard C. Johnson of Tuscumbia.

The announcement was made by the medical society, which also revealed that Dr. Johnson had been named Chief of Staff of Colbert Hospital.

Other officers of the hospital staff include Dr. Wyatt Blake, III, vice chief of staff; Dr. Archie H. Carmichael, chief of medicine; Dr. Foy E. Blue, chief of surgery; Dr. Kermit Mitchell, chief of obstetrics and gynecology; and Dr. James A. Mitchell, secretary.

Other society officers named include Dr. Robert Campbell, secretary-treasurer, and Dr. H. C. Hamilton, president-elect.

JACKSON PHYSICIAN HEADS MEDICAL GROUP

Dr. W. H. Curtright will serve as president of the Clarke County Medical Society for the coming year.

He and two other doctors from Jackson, W. F. deShazo and J. P. Mudd, Jr., were named at the December meeting at Grove Hill.

Dr. deShazo will serve as vice-president and president-elect; and Dr. Mudd as secretary-treasurer.

Dr. Curtright replaces Dr. Margaret Henry of Thomasville in the presidency.

Named to the County Board of Health were Dr. Mudd, chairman; Drs. Henry, W. H. Rudder, Palmer H. Warren, and Charles E. May.

Delegates to the April Annual Session of the Medical Association were Drs. Warren and Mudd, with Drs. May and Curtright as alternates.

the price of "success"

190
102

Hypertension has been called the price of success... and in some life-situations, the cost of failure. In either event, Metatensin lowers blood pressure, cushions the patient against stress and retards the progress of disease. Metatensin is effective and economical. It is well-tolerated over long periods.

THERAPY
YOU CAN STAY
WITH

METATENSIN®

EACH SCORED TABLET CONTAINS:
Metahydrin® (trichlormethiazide) 2 mg. or 4 mg. Reserpine 0.1 mg.

In Brief: Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery. Contraindications are complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.
Supplied: Metatensin tablets, 2 mg., 4 mg. — bottles of 100 and 1000.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

Pictured below are the officers and participants on the program.



Left to right: Lt. Col. James D. Weaver, USAFR, Bioastronautics Section, Andrews Air Force Base, Maryland; Dr. Ralph V. Platou, Professor and Chairman, Department of Pediatrics, Tulane University School of Medicine, New Orleans, Louisiana; Congressman Glenn Andrews, 4th District, Alabama.



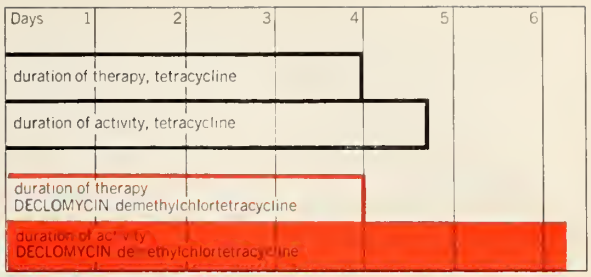
Left to right: Lt. Col. James D. Weaver, USAFR, Bioastronautics Section, Andrews Air Force Base, Maryland; Dr. James H. Johnston, Associate Clinical Professor of Surgery, University of Mississippi School of Medicine, Jackson, Mississippi; Dr. Albert B. Stephens, Jr., Assistant Professor, Department of Psychiatry, University of Alabama, Birmingham, Alabama; Dr. Robert L. Flynn, Assistant Chief, Coronary Heart Disease Section, U. S. Public Health Service, Washington, D. C.; Dr. Ralph V. Platou, Professor and Chairman, Department of Pediatrics, Tulane University School of Medicine, New Orleans, Louisiana; Dr. Warren G. Sarrell, Chairman of Seminar, Anniston, Alabama; Dr. G. G. Woodruff, Jr., President Calhoun County Medical Society, Anniston, Alabama.

THE RIGHT TO PRESCRIBE—RIGHT

This gets down to the really basic controversy, where one exists, between physicians and welfare agencies on drug costs. We are willing, indeed we are anxious to prescribe economical drugs for our patients, whether on welfare or paying their own way—but it has to be the **right** drug. It is when we are denied the opportunity to provide for our patients the proper drug for their treatment, simply on a basis of cost, that we rebel.—Burtis E. Montgomery, M. D., in **Illinois Medical Journal**, (128:614), December 1965.

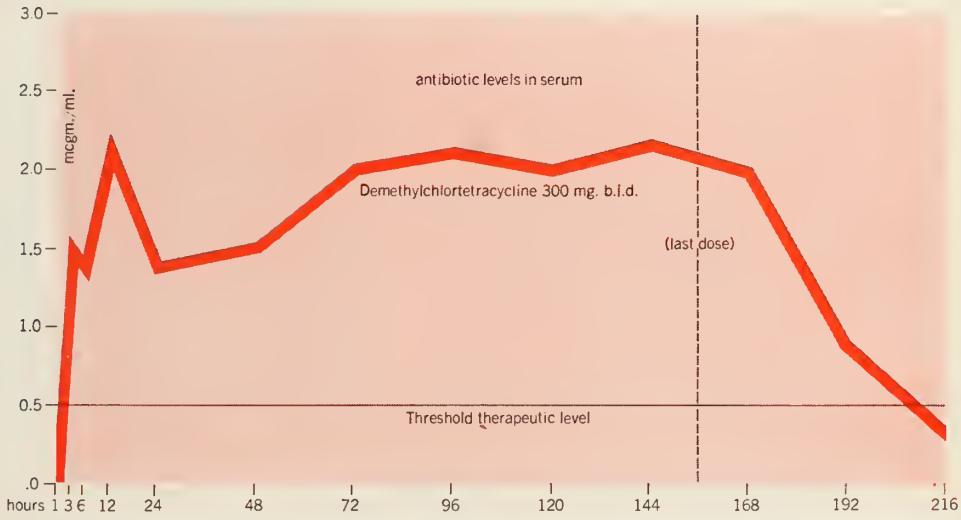


lower mg. intake per 24 hours
600 mg. versus 1000 mg.

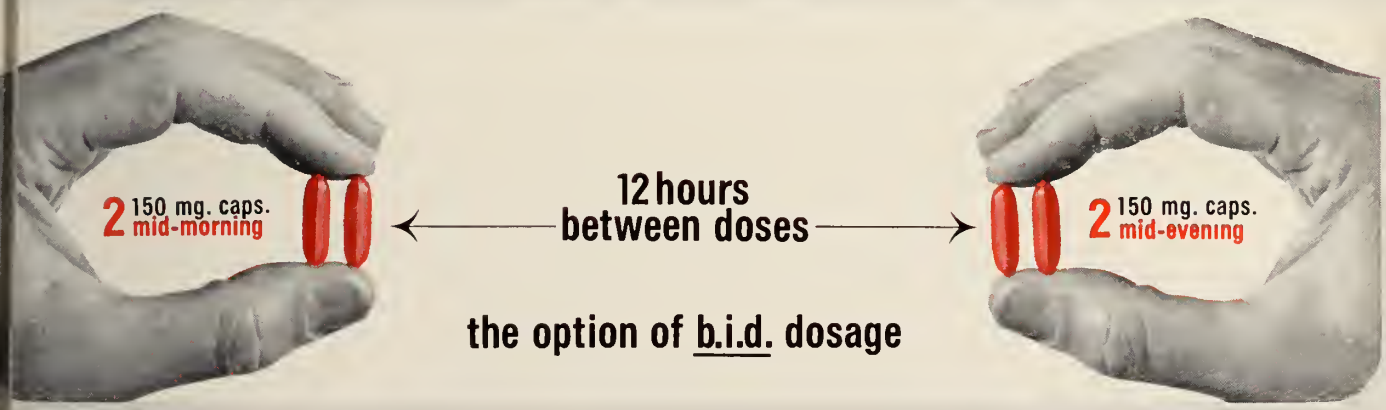


1-2 days'"extra"activity

higher activity levels than other tetracyclines—with less peak-and-valley fluctuation



From Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.; Amer. J. Med. Sci. 243:296 (Mar.) 1962



the option of b.i.d. dosage

he"extra"benefits raise the evel of antibiotic control

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE
150 mg. CAPSULES

ffective in a wide range of everyday infections—respiratory, urinary act and others—in the young and aged—the acutely or chroni- ally ill—when the offending organisms are tetracycline-sensitive.

ide effects typical of tetracyclines include glossitis, stomatitis, roctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of onsusceptible organisms, tooth discoloration (if given during ooth formation) and increased intracranial pressure (in young nfants). Also, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. Because of reactions to artificial or natural sunlight (even from short exposure and at low dosage), patient should be warned to avoid direct exposure. Stop drug immediately at the first sign of adverse reaction. It should not be taken with high calcium drugs or food; and should not be taken less than one hour before, or two hours after meals.

Capsules, 150 mg. and 75 mg. of demethylchlortetracycline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 mg. b.i.d.

.EDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

8035-9720

a rapid lift from the hell of depression



Doré Illustration
from
Dante's Inferno

often relieves mental pain in 2-5 days

NORPRAMIN®
(desipramine hydrochloride)

Norpramin is a rapid-acting specific drug for the treatment of depression. Depressive signs and symptoms—sometimes described as "mental pain"—typically begin to improve in 2-5 days. Patients are more hopeful, less empty and less weighed down by their troubles. Norpramin has only slight sedative qualities, nevertheless anxiety *secondary to depression* is frequently relieved as depression is lifted. If anxiety or tension persists it can be controlled by adding a tranquilizer or by reducing dosage. Norpramin is not a MAO inhibitor. Side effects are usually mild.

DOSAGE AND ADMINISTRATION

Optimal results are obtained at a dosage of about 150 mg./day—two 25 mg. tablets t.i.d. After achieving optimal results, a maintenance dose (50-100 mg./day) should be sought.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

IN BRIEF:

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

Contraindications and Precautions: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established.

Adverse Effects: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

Supplied: Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

Alabama Department of Public Health

Important Letter To Presidents Of All County Medical Societies

This is a request that you remind private physicians in your county medical society of the availability of drugs for nonhospitalized, medically indigent, psychiatric patients. Patients do not need to have been in a hospital to be eligible for these drugs.

The Alabama Legislature in 1963 appropriated $100,000 to provide drugs for medically indigent, nonhospitalized, mentally ill patients.

A State Drug Committee was appointed to work with Dr. Tarwater to develop a practical plan for distribution of these drugs. The Committee decided on two plans by which patients may obtain drugs prescribed for them.

A supply of drugs is kept in local mental health clinics to be dispensed free to clinic patients who are medically indigent. Also, clinics will dispense drugs on a physician's prescription without the patient being admitted to the mental health clinic for treatment, or a private physician may obtain drugs for psychiatric patients by sending the patient's prescription to Bryce Hospital. The drugs then will be mailed to the physician or directly to the patient if the latter procedure is preferred.

Any patient receiving drugs through the state drug program must be under medical supervision. Emphasis has been placed on the patient's continued contact with his physician.

When a patient leaves the state psychiatric hospital he now is given a two weeks' supply of the drugs prescribed for him. Before the expiration of this two weeks' supply, the hospital mails the patient an additional two weeks' supply. This plan, made possible by the drug fund, gives county health department public health nurses who are following psychiatric patients in their homes time to receive from the state hospital notice of the patient's return home with information about his condition and recommendations for continued treatment. The public health nurse then visits the home and refers the patient to his physician for recommendations about care and continuation of drugs prescribed by the hospital physician.

Lack of funds for psychiatric drugs has been one of the biggest obstacles to the patient's adjustment to his home and community. Before drugs were available without charge, many patients doubtless returned to the hospital because they were unable to purchase drugs needed to control their symptoms and to further and maintain personality integration.

The State Drug Committee wants all physicians in Alabama to know that this state financed drug program makes it possible for mentally ill patients who are unable to pay to obtain prescribed drugs.

We shall appreciate your again bringing this information to the attention of private physicians in your county.

Sincerely yours,

Ira L. Myers, M. D.
State Health Officer
Alabama Department
of Public Health

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

November 1965

Examination for intestinal parasites	1,304
Typhoid cultures (Blood, feces, urine and other)	302
Examinations for malaria	2
Examinations for gonococci	1,917
Serologic tests for syphilis (blood and spinal fluid)	24,269
Darkfield Examinations	2
Agglutination Tests	7
Examinations for diphtheria bacilli and vincent's	1,110
Complement fixation tests	202
Examinations for Negri bodies (smears and animal Inoculations)	305
Water examinations	2,394
Milk and dairy products examinations	3,646
Examinations for tubercle bacilli	3,789
Miscellaneous examinations	9,595
Total	48,844

* * *

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

Current Morbidity Statistics

1965

	Oct.	Nov.	*E. E. Nov.
Tuberculosis	144	107	111
Syphilis	164	165	117
Gonorrhea	459	364	265
Chancroid	1	2	2
Typhoid fever	2	1	1
Undulant fever	0	0	0
Amebic dysentery	4	0	3
Scarlet fever & strep. throat	350	374	94
Diphtheria	0	9	6
Whooping cough	2	3	15
Meningitis	6	6	6
Tularemia	0	0	0
Tetanus	2	1	1
Poliomyelitis	0	0	5
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	16	6	44
Chickenpox	2	15	21
Mumps	8	13	34
Infectious hepatitis	31	26	36
Typhus fever	0	0	0
Malaria	0	0	0
Cancer	728	763	462
Pellagra	1	0	0
Rheumatic fever	15	9	14
Rheumatic heart	25	19	24
Influenza	150	330	96
Pneumonia	232	216	170
Rabies—Human cases	0	0	0
Pos. animal heads	0	0	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF VITAL STATISTICS

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA.

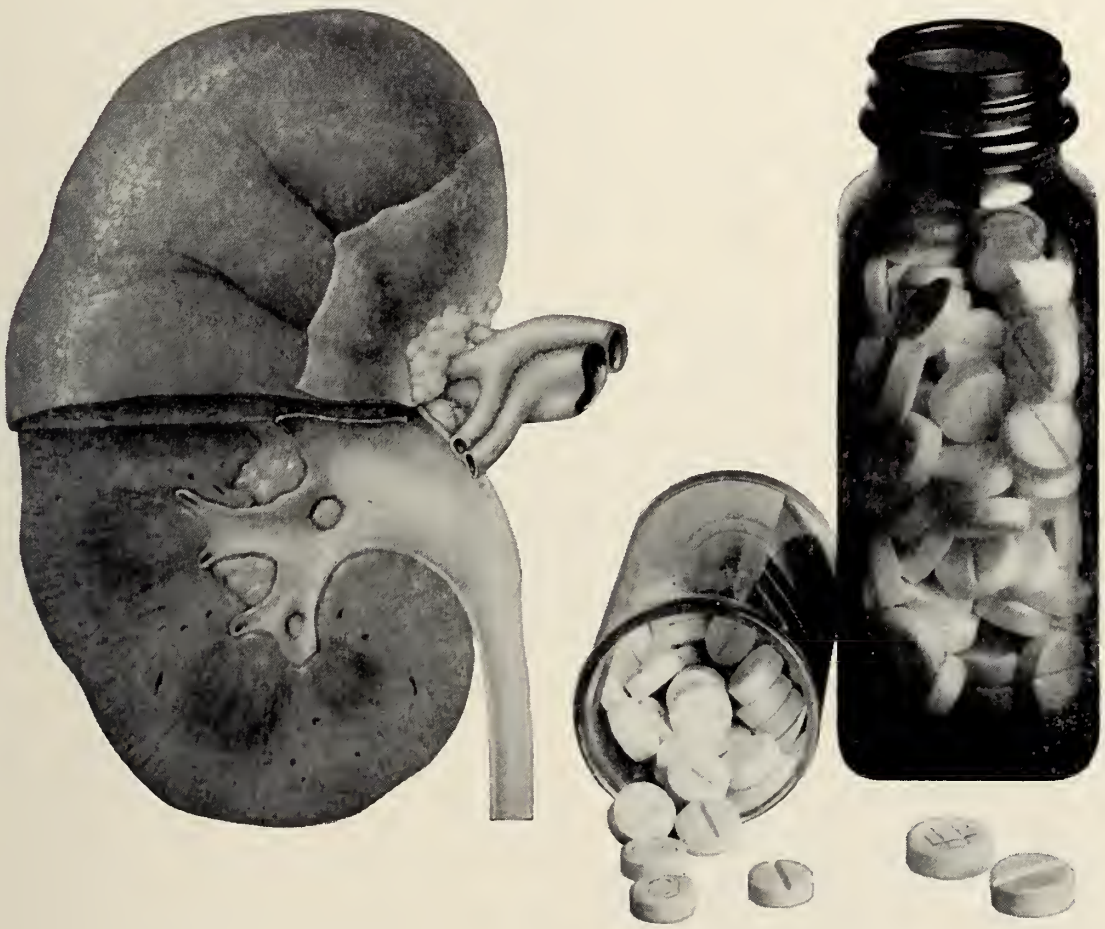
SEPTEMBER 1965

Ralph W. Roberts, M. S., Director

Live Births / Deaths / Causes of Death	Number Registered During September			Rates* (Annual Basis)		
	Total	White	Non-White	1965	1964	1963
Live Births	6,445	4,107	2,338	22.5	24.3	25.4
Deaths	2,440	1,633	807	8.5	8.5	8.5
Fetal Deaths	130	52	78	19.8	17.8	18.3
Infant Deaths—						
under one month	113	67	46	17.5	20.3	19.0
under one year	145	82	63	22.5	28.7	24.9
Maternal Deaths	4	2	2	6.1	10.1	4.2
Causes of Death						
Tuberculosis, 001-019	20	8	12	7.0	5.4	4.7
Syphilis, 020-029	5	1	4	1.7	1.4	1.8
Dysentery, 045-048	1	1		0.3	0.7	0.7
Diphtheria, 055	1		1	0.3	0.4	
Whooping cough, 056					0.7	0.4
Meningococcal infections, 057					1.1	
Poliomyelitis, 080, 081					0.4	
Measles, 085						
Malignant neoplasms, 140-205	360	263	97	125.8	124.7	123.4
Diabetes mellitus, 260	26	16	10	9.1	10.4	8.3
Pellagra, 281						0.4
Vascular lesions of central nervous system, 330-334	316	210	106	110.5	119.3	138.6
Rheumatic fever, 400-402					0.4	0.4
Diseases of the heart, 410-443	821	581	240	287.0	262.6	275.3
Hypertension with heart disease, 440-443	96	35	61	33.6	33.3	40.4
Diseases of the arteries, 450-456	56	34	22	19.6	15.8	20 6
Influenza, 480-483	2	1	1	0.7	0.4	1.1
Pneumonia, all forms, 490-493	43	29	14	15.0	18.3	18.0
Bronchitis, 500-502	5	3	2	1.7	1.4	1.8
Appendicitis, 550-553	1		1	0.3	2.1	1.4
Intestinal obstruction and hernia, 560, 561, 570	14	12	2	4.9	5.7	4.7
Gastro-enteritis and colitis, under 2, 571.0, 764	5	1	4	1.7	4.3	3.2
Cirrhosis of liver, 581	19	15	4	6.6	3.6	5.3
Diseases of pregnancy and childbirth, 640-689	4	2	2	6.1	10.1	4.2
Congenital malformations, 750-759	29	21	8	4.5	4.6	3.8
Immaturity at birth, 774-776	32	15	17	5.0	5.6	6.0
Accidents, total, 800-962	185	134	51	64.7	55.9	55.6
Motor vehicle accidents 810-835, 960	106	75	31	37.1	28.3	33.6
All other defined causes	370	231	139	129.3	137.9	128.1
Ill-defined and unknown causes, 780-793, 795	125	55	70	43.7	51.2	31.0

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population

at Merck Sharp & Dohme...



understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

• Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

Turn a bundle of colic



into a bundle of joy





COLIC, often in part a reflection of family tension, adds sleepless nights to patients' and parents' distraught days. Pediatric Piptal with Phenobarbital slows down spasm, diminishes pain and crying, improves feeding patterns . . . permits sleep and rest . . . for patient and family.

Pleasant tasting Pediatric Piptal with Phenobarbital is miscible in milk, formulas and fruit juices, and may also be administered by dropper directly on the infant's tongue. Dosage is 0.5 cc. 15 minutes before feeding; in severe cases, 1.0 cc. four times daily. High doses may occasionally cause constipation with tenesmus and, rarely, flushing without fever. Contraindicated in bowel obstruction or sensitivity to phenobarbital or anticholinergics. Available in 30 cc. dropper bottles, droppers calibrated to deliver 0.5 cc.

PEDIATRIC PIPTAL® WITH PHENOBARBITAL

each cc. contains: 6 mg. phenobarbital (warning: may be habit forming); 4 mg. Piptal® (pipenzolate bromide), and 20% alcohol in a pleasant-tasting solution.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201



Prompt relief of pain and spasm in functional g.i. distress...



PIPTAL® (pipenzolate bromide) efficiently suppresses acid secretion and motility ... relieves pain and spasm of peptic ulcer. Despite its potent gastrointestinal effects, "its clinically effective therapeutic dose is well below that required to produce side reactions."[1] Because urinary retention is rarely a problem, PIPTAL (pipenzolate bromide) is "a highly desirable drug in the treatment of peptic ulcer in older patients ..."[2] Tolerance to PIPTAL (pipenzolate bromide) has not been demonstrated, and the drug may be administered over prolonged periods without loss of efficacy. *PIPTAL-PHB is specifically designed for the tense ulcer patient who will benefit from the sedative effect of phenobarbital.*

1—Pomeranze, J., and Gadek, R.J.: Am. Pract. & Digest Treat. *8*:73-77 (Jan.) 1957
2—Asher, L.M.: Am. J. Digestive Diseases 4:272 (Apr.) 1959

PIPTAL®
(pipenzolate bromide)

PIPTAL®-PHB
(phenobarbital, 16 mg., pipenzolate bromide, 5 mg.)

IN BRIEF: PIPTAL—Each tablet contains 5 mg. pipenzolate bromide, PIPTAL-PHB—Each tablet (or 5 cc. of elixir) contains phenobarbital (warning: may be habit forming) 16.0 mg., Piptal (pipenzolate bromide) 5 mg. The elixir contains alcohol 20%.

Side Effects: Dry mouth, blurring of vision or drowsiness may occur.

Contraindications: Withhold in glaucoma, bladder or g.i. obstruction, cardiac arrhythmias and in sensitivity to anticholinergics or phenobarbital (Piptal-PHB). Caution should be observed in patients with prostatic hypertrophy.

Administration and Dosage: PIPTAL or PIPTAL-PHB Tablets: One tablet three times a day before meals and one or two tablets at bedtime. (PIPTAL-PHB Elixir: One teaspoonful three or four times daily for adults and children over six years of age.)

Supplied: PIPTAL (pipenzolate bromide) 5.0 mg. Tablets—bottles of 100. PIPTAL-PHB Tablets—bottles of 100. PIPTAL-PHB Elixir—bottles of 8 fluid ounces.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

Announcing...

THE TWENTY-NINTH ANNUAL MEETING

of

The New Orleans Graduate Medical Assembly

Conference Headquarters—Roosevelt Hotel

MARCH 7, 8, 9, 10, 1966

Guest Speakers

Robert J. Rowe, M. D., Dallas, Texas
Colon and Rectal Surgery

Walter C. Lobitz, Jr., M. D., Portland, Ore.
Dermatology

Bernard J. Haverback, M. D., Los Angeles, Calif.
Gastroenterology

Joseph J. Rupp, M. D., Philadelphia, Pa.
General Practice

Roy T. Parker, M. D., Durham, N. C.
Gynecology

Stefan S. Fajans, M. D., Ann Arbor, Mich.
Internal Medicine

John S. LaDue, M. D., New York, N. Y.
Internal Medicine

Joseph M. Foley, M. D., Cleveland, Ohio
Neurology

Duncan E. Reid, M. D., Boston, Mass.
Obstetrics

H. Saul Sugar, M. D., Detroit, Mich.
Ophthalmology

S. Benjamin Fowler, M. D., Nashville, Tenn.
Orthopedic Surgery

Walter P. Work, M. D., Ann Arbor, Mich.
Otorhinolaryngology

William O. Russell, M. D., Houston, Tex.
Pathology

William A. Silverman, M. D., New York, N. Y.
Pediatrics

C. Allen Good, M. D., Rochester, Minn.
Radiology

Louis M. Rousselot, M. D., New York, N. Y.
Surgery

Jerome A. Urban, M. D., New York, N. Y.
Surgery

Donald R. Smith, M. D., San Francisco, Calif.
Urology

Additional Speaker to be Announced

Lectures, symposia, clinicopathologic conferences, round-table luncheons, medical motion pictures, technical exhibits and entertainment for visiting wives. (All-inclusive registration fee—$25.00).

This program is acceptable for twenty-nine (29) accredited hours by the American Academy of General Practice.

The Clinical Tour AROUND THE WORLD visiting Hawaii, Tokyo, Nikko, Kyoto, Nara, Hong Kong, Bangkok, New Delhi, Agra, Jaipur, and Cairo. Leaving March 12 via air and returning April 12, 1966.

For information concerning the Assembly meeting and tour write Secretary, The New Orleans Graduate Medical Assembly, Room 1528, 1430 Tulane Avenue, New Orleans, Louisiana 70112.

Sparkling Soft Drinks...

pleasure for patients who need liquids



Soft drinks are welcomed by patients on a liquid diet and by those who need additional fluids to maintain bodily functions. Since the amount of liquids is so important, flavorful soft drinks are often recommended. Carbonated beverages are useful for replenishing liquids when fever is present or when other foods and beverages cannot be tolerated. There's a psychological advantage, too—patient is happy to follow doctor's orders when they are so pleasant and enjoyable. Write for "Sparkling Soft Drinks" and "Liquids for Living."

Alabama Bottlers Association

P. O. Box 2181

Montgomery, Alabama 36103

GRANTS TO IMPROVE NURSING EDUCATION MADE

The first grants to improve nursing education under the Nurse Training Act of 1964 have been made by the U. S. Department of Health, Education, and Welfare.

The grants, made available through the Public Health Service, total $2,746,714. They are for assistance under two provisions of the legislation: project grants to improve, strengthen, or expand nursing education programs; and payments to reimburse diploma (hospital) schools of nursing for some of the cost of increased enrollment resulting from other provisions of the Nurse Training Act.

A total of $1,989,564 for 39 project grants has been awarded to 35 diploma and collegiate schools of nursing located in 21 States, the District of Columbia, and Puerto Rico. The awards were made on the recommendation of the National Advisory Council on Nurse Training, which was created by the legislation. As required, each of the 35 schools which received project grant funds is accredited by the National League for Nursing or has reasonable assurance of accreditation. The projects range in duration from one to five years. Some of these projects will coordinate and improve teaching of medical-surgical nursing; others will extend experience of students in out-of-hospital settings; and still others will develop audio-visual aids for teaching nursing subjects.

Under the provision for assistance to diploma schools, 187 diploma programs accredited by the National League for Nursing have received payments totaling $757,150. These schools are located in 41 States, the District of Columbia, and Puerto Rico. Payments are determined by the increase in full-time enrollment for the current year over the average for the years 1962, 1963, and 1964; or by the number of full-time students who have received loan assistance under another provision of the Nurse Training Act; or both of these factors.

The Nurse Training Act authorizes up to $283 million during a five-year period to increase the supply of better qualified nurses through aid to students and nursing schools.

Grants to Alabama include: Holy Name of Jesus Hospital, Gadsden, $2,500; Mobile General Hospital, Mobile, $5,250; St. Margaret's Hospital, Montgomery, $1,750.

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BIRMINGHAM, ALABAMA

BUREAU OF VITAL STATISTICS
PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA,

OCTOBER, 1965

Ralph W. Roberts, M. S., Director

Live Births / Deaths / Causes of Death	Number Registered During October 1965			Rates* (Annual Basis)		
	Total	White	Non-White	1965	1964	1963
Live Births	6,178	3,888	2,290	20.9	23.8	23.9
Deaths	2,686	1,803	883	9.1	9.2	8.7
Fetal Deaths	107	44	63	17.0	20.6	21.2
Infant Deaths—						
under one month	107	54	53	17.3	23.1	22.4
under one year	161	74	87	26.1	31.8	30.3
Maternal Deaths	2		2	3.2	1.4	10.0
Causes of Death						
Tuberculosis, 001-019	21	12	9	7.1	7.3	10.5
Syphilis, 020-029	1		1	0.3	1.4	1.4
Dysentery, 045-048					0.7	
Diphtheria, 055	1		1	0.3	0.3	
Whooping cough, 056						
Meningococcal infections, 057	1	1		0.3	1.0	1.4
Poliomyelitis, 080, 081						
Measles, 085	1	1		0.3	0.3	
Malignant neoplasms, 140-205	366	264	102	123.8	129.7	123.6
Diabetes mellitus, 260	37	23	14	12.5	16.6	10.8
Pellagra, 281	1	1		0.3		
Vascular lesions of central nervous system, 330-334	388	269	119	131.3	132.4	111.4
Rheumatic fever, 400-402						0.3
Diseases of the heart, 410-443	906	678	228	306.5	294.7	285.6
Hypertension with heart disease, 440-443	119	60	59	40.3	33.6	40.2
Diseases of the arteries, 450-456	64	39	25	21.6	20.1	20.2
Influenza, 480-483					0.7	1.0
Pneumonia, all forms, 490-493	77	47	30	26.0	23.6	22.3
Bronchitis, 500-502	1		1	0.3	1.7	1.4
Appendicitis, 550-553					0.3	0.7
Intestinal obstruction and hernia, 560, 561 570	13	4	9	4.4	5.9	4.5
Gastro-enteritis and colitis, under 2, 571.0, 764	9	1	8	3.0	3.5	4.5
Cirrhosis of liver, 581	23	16	7	7.8	6.2	9.1
Diseases of pregnancy and childbirth, 640-689	2		2	3.2	1.4	10.0
Congenital malformations, 750-759	25	16	9	4.0	3.8	4.7
Immaturity at birth, 774-776	40	18	22	6.5	6.3	7.3
Accidents, total, 800-962	172	129	43	58.2	62.4	60.1
Motor vehicle accidents, 810-835, 960	108	86	22	36.5	31.6	29.7
All other defined causes	382	237	145	129.2	136.3	127.5
Ill-defined and unknown causes, 780-793, 795	155	47	108	52.4	50.6	45.0

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population



Be alert to Cancer's Seven Danger Signals

1. Unusual bleeding or discharge
2. A lump or thickening in the breast or elsewhere
3. A sore that does not heal
4. Change in bowel or bladder habits
5. Hoarseness or cough
6. Indigestion or difficulty in swallowing
7. Change in a wart or mole

See your doctor immediately if any of Cancer's Seven Danger Signals lasts more than two weeks.

See your doctor every year for a health checkup.

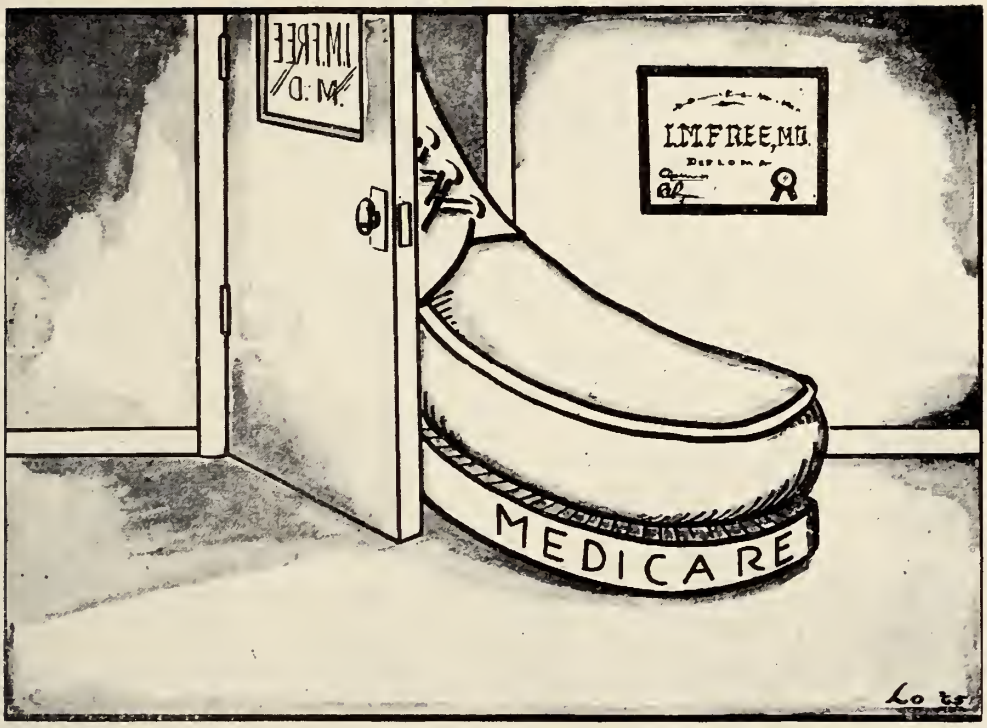
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Improved and more effective tranquilizers that do not produce drowsiness or other undesirable side effects will some day be available. Indeed, these future drugs affecting the nervous system and our moods will be aimed toward specific clinical indications. Some will be designed to aid in concentration, improve the memory, and accelerate the thinking process. These so-called "smart pills" will also increase alertness during stressful periods and also assist slow learners and retarded persons. Others will remove grief and sadness, and some may be useful in alcoholism and other character disorders. Austin Smith, M. D., in *Emory University Quarterly*, Summer 1965.

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The Woman's Auxiliary

SOUTHEAST DISTRICT MEETING

The wives of the doctors in Ozark served as hostesses to the Southeast District of the Medical Auxiliary. About 45 members met at the Holiday Inn on October 27. Mrs. C. N. Matthews of Florala, District Vice-President, conducted the meeting.

Informative reports on Rural Health, Radio and TV, Disaster Preparedness, WAMASA Newsletter, and Nominating were made by state committee chairmen or their representatives. An enlightening talk on the importance of participation in AMPAC and ALAPAC, the political actions committees of medicine, was given by Mrs. John Kimmey. Greetings from the Northeast District were brought by Mrs. Eugene Bradley. Four presidents, from Coffee, Covington, Houston, and Montgomery Counties, made progress reports on the work of their respective auxiliaries.

The focal point of the meeting was in the accounts given by Mrs. James Crenshaw and Mrs. Ira Patton from their attendance at the regional workshop recently held in Atlanta. Mrs. Crenshaw's emphasis was placed on Health Careers and Community Service. Mrs. Patton was especially inspiring in her efforts to tell us how to interest more wives of doctors in active Auxiliary work.

Decorations for the luncheon followed the Halloween motif. The centerpiece on the table, clever favors, mum corsages, and the enormous black cat on the piano drew many comments. During the luncheon hour Mrs. George Johnson of Dothan graciously entertained with a medley of piano selections. These were original compositions which have been successfully published.

Mrs. George Andrews, Disaster Preparedness Chairman, introduced William Fleming from the State Health Department. He spoke briefly on the urgency for a knowledge of Medical Self-Help by at least one person in every family. He re-inforced his remarks by showing the very dramatic film, "If Disaster Strikes." No one present could fail to feel the impact of the message as narrated by Danny Thomas.

To borrow a statement from Mrs. Patton: "If Ozark can do this well without a Medical Auxiliary, just think what they could do if they were organized." Dale County, you have a real challenge!

Mrs. C. N. Matthews

Vice-President, Southeast District

PHYSICIAN PLACEMENT SERVICE IN ALABAMA

The Physician Placement Service of the Medical Association of the State of Alabama is designed to assist both physicians and communities. Further information is available from the central office, 19 South Jackson Street, Montgomery, Alabama 36104—*or Phone* 263-6441.

LOCATIONS WANTED

General and Thoracic Surgeon, age 30, Protestant, Married, Vanderbilt 1959. Resid. Vanderbilt and Univ. of Pa. Seeking location in town of 75,000 or larger. Available now. LW-22

General Surgeon, age 31, Protestant, Tulane Med. School 1961. Resid. in Gen. Surgery. Married, Military oblg. completed, available June 1966. LW-23

General Surgeon, age 31, Tufts Med. School 1955, Married. Completed U. S. Navy, passed National Boards, certified Am. Boards. Seeking location solo, associate or institutional. LW-24

General Surgeon, age 31, native Ala., Protestant. Med. Col. of Ala. 1958. Completing resid. June 1966, completed USAF duty. Seeking solo, associate or group practice. LW-25

Ob-Gyn, age 31, Jewish, Univ. of Miami 1959; Married, elig. Am. Boards, completing USAF 1966. Seeking location as associate, group or solo. LW-26

Pathologist, age 41, Univ. of Okla. 1952; Protestant, eligible Am. Boards. Seeking location in solo, group or associate. Available now. LW-27

Radiologist, age 43, Yale Univ. School of Med., certified in all phases but prefers to limit practice to Diagnostic Radiology. Seeking loc. in group or association. On active duty USAF, available July 1966. LW-28

Radiologist, age 33, Catholic, Indiana Univ. Med. School, married. Completed Army duty, certified Am. Boards. Seeking location solo or associate. Available Dec. 1965. LW-29

Gen. Practitioner, age 39, Protestant, Univ. of Arkansas 1955. Elig. Am. Boards, military oblg. completed. Seeking association in private practice. LW-30

General Practitioner, Epidemiology, Public Health and Pharmaceutical, age 45, Catholic, Geo. Wash. Univ. 1948. Married, passed Nat. Boards. Seeking industrial or institutional practice. Available now. LW-31

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N. Alabama town with 15,000 pop. seeking five GP's. Town has 117-bed hospital with open membership. Industrial expansion at all-time high, workers commute to Redstone and Birmingham. Many lakes and streams offer recreational facilities. Schools and colleges near. PW-14

NE Alabama town of 600 with trade area of 12,000 seeking GP and Surgeon. Hospitals and clinics available 13 miles away. Large city facilities 50 miles. New modern clinic and all equipment furnished. Farming, textiles, pulpwood, and other industries stabilize the economy. New and modern school and churches, social and recreational facilities. PW-15

S. Ala. town of 817 without doctor since last one left to specialize. City-owned clinic offered rent-free, fully equipped. Nearest hospitals located 10 miles away, membership on staff open. Principally agricultural region, with textiles, industry, and Fort Rucker payroll. Exc. city schools and large trade school just completed. Other educational advantages in nearby towns. Recent waterways development is increasing industrial and recreational opportunities, ideal climate, just 50 miles from Gulf Coast. PW-16

NW Ala. town of 3,500, trade area 10,000 seeking GP and Surgeon. Hospital in town, one other in county. Office space and home available near hospital. Excellent schools, four churches, country club, golf course, various clubs. Economy principally industry, lumber, cotton gins, commercial and agriculture. Near Univ. of Alabama. PW-17

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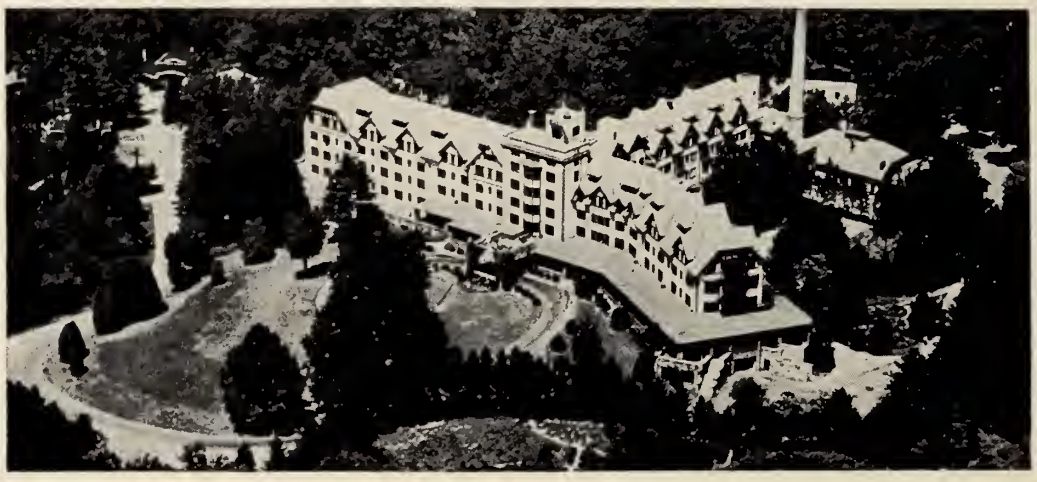
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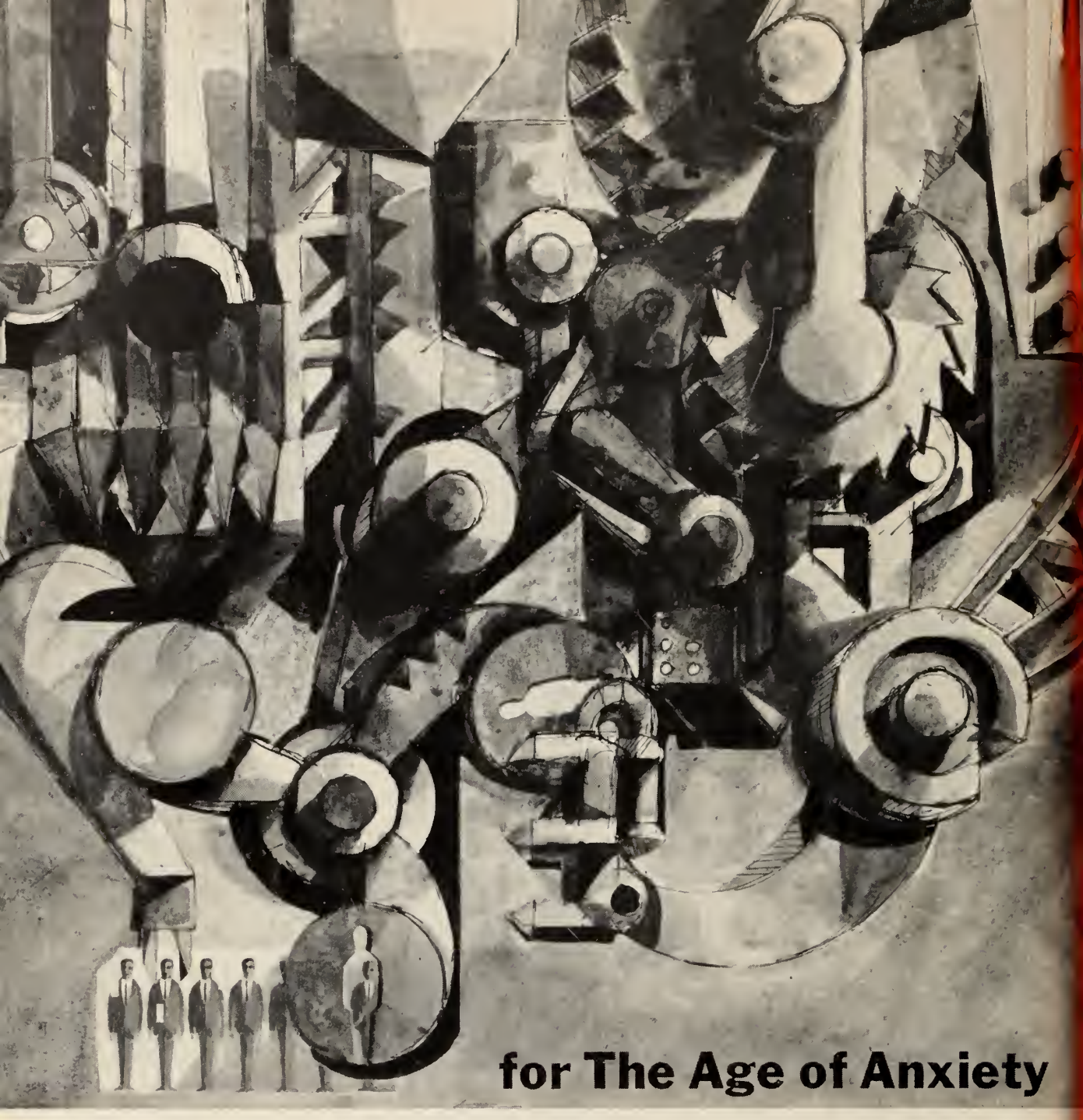
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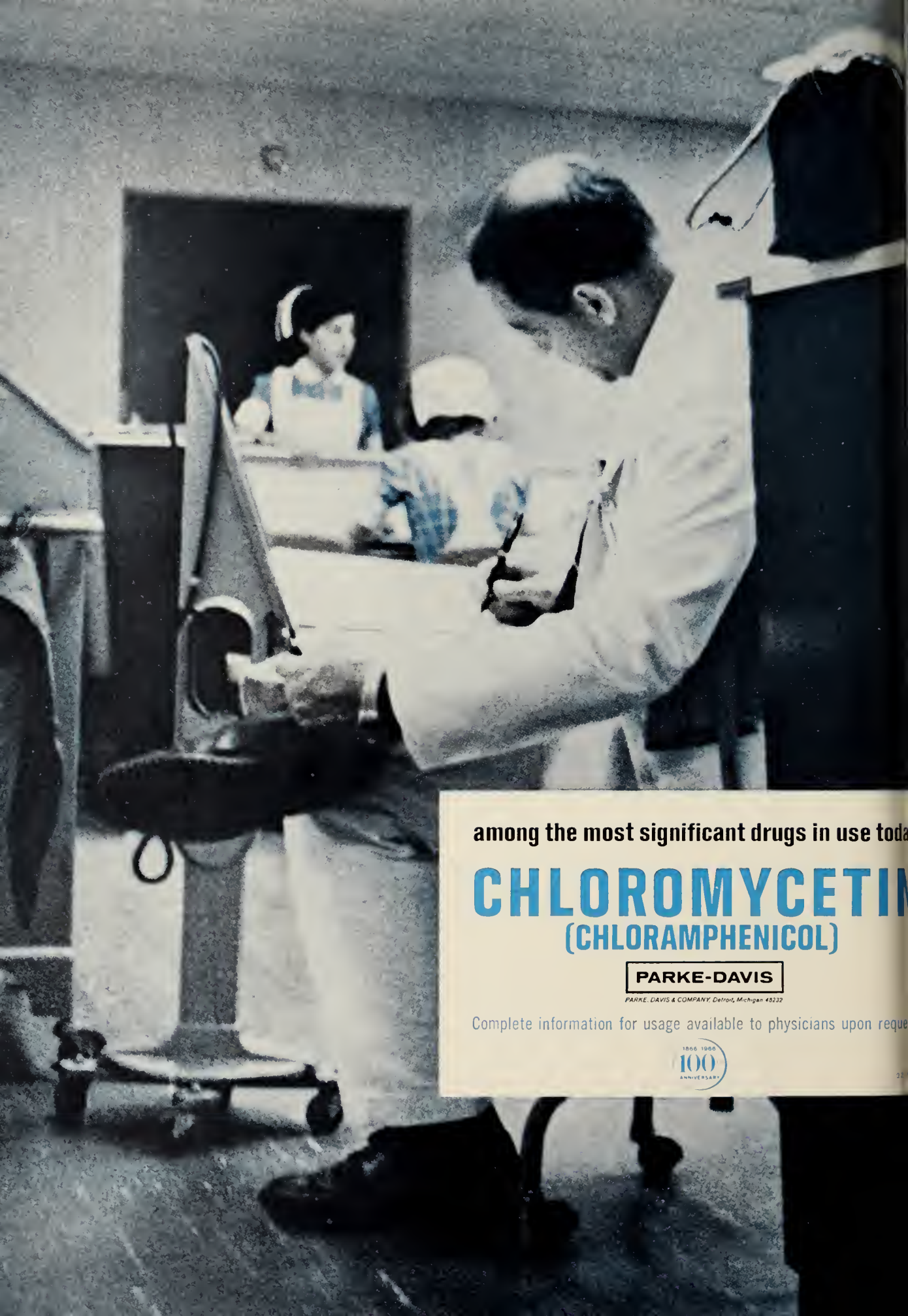
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(1) Portnoy, J.: Brewer, J. and Harris, A.: PUBLIC HEALTH REPORTS, *77:*645-652, August 1962. (2) Joseph, J. M. and Warner, G. S.: A WORKSHOP MANUAL, Md. State Dept. Health, Bureau of Lab., Balto., Md., September 1962. (3) Wollenweber, H. L.: OFF. PATH., *2*, February 5, 1963. (4) Portnoy, J.: MILIT. MED., *128:*414-417, May 1963. (5) Portnoy J.: THE AMER. JOUR. OF CLIN. PATH., *40:*473-479, November 1963. (6) Buck, A. A. and Mayer, H.: THE AMER. JOUR. OF HYG., *80:*85-90, July 1964. (7) Brown, W. J.; Donohue, J. F. and Price, E. V.: PUBLIC HEALTH REPORTS, *79:*496-500, June 1964. (8) Clayton, J. L.; Lindhardt, E. M. and Fraser, R. S.: PUBLIC HEALTH LAI *22:*206-207, November 1964. (9) Lucatorto, F. M.; Katz, B. D. and Toto, P. D.: THE J.A.D.A., *69:*697-699, December 1964. (10) Portnoy, J.: PUBLIC HEALTH LAB., *23:*43, March 1965. (11) Reed, E. L.: PUBLIC HEALTH LAB., *23:*96-103, May 1965.

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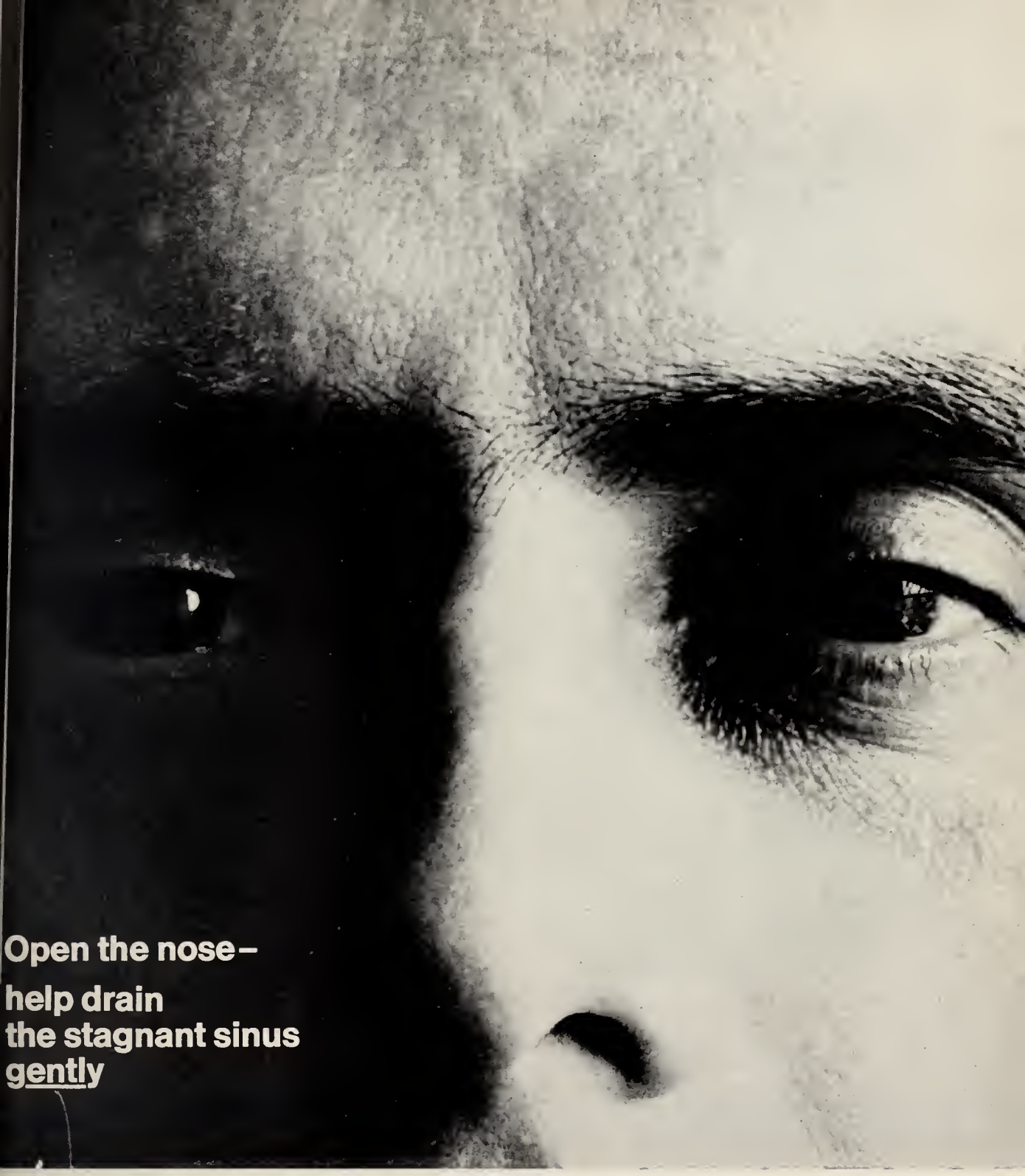
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*Proctor, D. F.: The Nose, Paranasal Sinuses, and Ears in Childhood, Springfield, Ill., Charles C Thomas, 1963, p. 34.

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President's Page



For years the medical staffs of hospitals have been expected and required to assume responsibility for the quality of medical care within each hospital. This has been done through the proper functioning of tissue committees, committees on infection, records committees and the departmental services committees. For the past five years many hospitals have recognized the need for an additional medical staff function—i.e.—a review of the use of hospital facilities to determine whether such utilization has been efficient, proper, and in accordance with the best good for all sick people of the community. In 1960 the Board of Trustees of the American Medical Association and the American Hospital Association approved as a principle the statement that the hospital medical staff should "Evaluate the Quality of Medical Care on the Basis of Documented Evidence to Support Diagnoses, Treatment, and Justify Utilization of Hospital Facilities." This principle was noted in the August, 1963, bulletin of the Joint Commission on Accreditation of Hospitals.[1] At the annual meeting of the Commissioners on December 11, 1965, the Joint Commission on Accreditation of Hospitals added a requirement for utilization review to the standards for accreditation. In addition to the utilization requirements it also added to the functions previously required of medical staffs those concerned with hospital acquired infections, pharmacy and therapeutic practices.

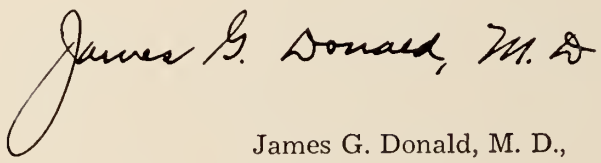
Public Law 89-97 ("Medicare") will begin to function July 1st, 1966. In order for a hospital to be approved as a provider of services under the law a mechanism for formal utilization review of the professional work done will be required. The law provides that this may be done by either—A. A staff committee of the institution composed of two or more physicians with or without participation of other personnel, or—B. A group outside the institution which is similarly composed and (1) which is established by the local medical society and some or all of the hospitals and extended care facilities of the locality, or (2) if and for as long as there has not been established such a group which serves such institution one be approved by the Secretary of Health, Education and Welfare.[2]

Since the Joint Commission on Accreditation of Hospitals now requires a utilization review committee it seems likely that hospitals which are accredited by the Joint Commission will automatically be accepted as provider of services under Public Law 89-97 because the proper functioning of such a utilization review committee will have already been established and approved as a condition for accreditation.

(Continued on Page 584)

The American Medical Association has consistently recommended that utilization review committees be composed of physicians and that where possible these review committees function as staff committees of hospitals. Certainly none of us want any utilization review to be carried out by individuals who are not qualified to judge the medical requirements of a particular case and to evaluate the effective utilization of beds, X-ray services, laboratory and nursing services. This is a matter which only physicians are qualified to evaluate.

It is urged that the organized medical staff of each hospital in the State of Alabama take steps promptly to establish a utilization committee composed of physicians of the medical staff. In areas where it is not appropriate for the staffs of the hospitals to assume this responsibility it is recommended that county medical societies establish such committees of physicians for utilization review. This should be done promptly so that the committees are functioning effectively to insure accreditation of the hospital and to assure that there will be no problem in having the hospital certified as a provider of services under Public Law 89-97 if such is desired. It cannot be too strongly emphasized that this duty should be assumed by physicians so that such review committees will not be established by outside agencies or be composed of individuals who are not physicians and are therefore not qualified to judge matters of utilization.



James G. Donald, M. D.,
President

1. *Utilization Review*—Handbook for the Medical Staff—Published by AMA Council on Medical Service, Page 1, 1965.

2. P. L. 89-97 (Medicare).

DEPROL®

meprobamate 400 mg. +
benactyzine hydrochloride 1 mg.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.
Before prescribing, consult package circular.

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benactyzine hydrochloride 1 mg.

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even when complicated by anxiety, tension, insomnia, agitation or rumination.

- **Acts rapidly.**
- **Side effects at recommended dosage infrequent, usually easily controlled.**

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Doré Illustration
from
Dante's Inferno

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DOSAGE AND ADMINISTRATION

Optimal results are obtained at a dosage of about 150 mg./day—two 25 mg. tablets t.i.d. After achieving optimal results, a maintenance dose (50-100 mg./day) should be sought.

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IN BRIEF:

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions.

Contraindications and Precautions: Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established.

Adverse Effects: Side effects, usually mild, may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs.

Supplied: Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

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Eight out of 10 patients respond

In clinical trials, Eutron produced normotension or a significant reduction in blood pressure in eight out of 10 patients studied. The rationale for the product is this: Eutonyl used alone is a potent antihypertensive. Its antihypertensive action is markedly enhanced by Enduron, a potassium-sparing thiazide.[1,2,3] The combination (Eutron) thus produces greater antihypertensive effect with lower dosages of the Eutonyl component, and milder side effects may be seen.

512214

1. Torosdag, S., Schvartz, N., Fletcher, L., Fertig, H., Schwartz, M. S., Quan, R. F. B., and Bryant, J. M., Pargyline Hydrochloride as an Antihypertensive Agent With and Without A Thiazide, Am. J. Cardiol., 12:822, Dec., 1963.

2. Pollack, P. J., Pargyline Hydrochloride and Methyclothiazide Combined In The Treatment of Hypertension, Cur. Thera. Res., 7:10, Jan., 1965.

3. Bryant, J. M. et al., Antihypertensive Properties of Pargyline Hydrochloride, New Non-Hydrazine Monoamine Oxidase Inhibitor Compared with Sulphonamide Diuretics, J.A.M.A., 178; 406, Oct., 1961.



BP reductions in the recumbent and sitting positions often are nearly as great as in the standing. In clinical trials, the average *recumbent* BP reduction was 36/18 mm. Hg.



The average *standing* reduction in clinical trials was 45/22 mm. Hg. Thus the difference between the standing and recumbent readings was only 9/4 mm. Hg.

Significantly lowers blood pressure in all body positions; less likelihood of orthostatic hypotension

In clinical trials, the average reduction in standing blood pressure was 45/22 mm. Hg.; in the sitting position it was 48/20 mm. Hg.; and in the recumbent position, 36/18 mm. Hg.

Because Eutron effectively reduces blood pressure in all body positions, there is reduced likelihood of orthostatic symptoms or hypotension.

This was reflected in the relatively mild character of side effects seen in clinical trials (see below).

Smooth and gradual onset

Onset of antihypertensive action is usually quite smooth. Initial reduction of systolic and diastolic readings is usually seen within a week – maximum reduction in seven to ten days.



Less troublesome side effects may be seen; frequent improvement in "sense of well-being"

Fewer than 1% of patients studied discontinued Eutron therapy because of side effects. This is due in part to the relatively low dosage needed with the combination. Usual recommended dose is one tablet daily–that is, 25 mg. Eutonyl with 5 mg. Enduron. *This is about half the usual therapeutic dose of Eutonyl given alone.* As a consequence side effects may be milder. And, as with Eutonyl given alone, the patient may well note an increased sense of well being. This is in distinct contrast to most other antihypertensive therapy.

ABBOTT

Prescribing information for EUTRON

INDICATIONS: Eutron (pargyline hydrochloride and methyclothiazide) is indicated in the treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. It is not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

CONTRAINDICATIONS: Eutron is contraindicated in patients with pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained it cannot be recommended for use in patients with malignant hypertension, children (under 12 years of age), or pregnant patients.

The concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. A drug-free interval of two weeks should separate therapy and use of these agents.

WARNINGS: Pargyline hydrochloride is a monoamine oxidase inhibitor. Patients should be warned against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When it is necessary to administer alcohol, narcotics (notably meperidine), antihistamines, anesthetics, barbiturates and other hypnotics, sedatives, tranquilizers, or caffeine, these agents can be used cautiously at a dosage of ¼ to ⅕ the usual amount. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Patients should be warned about the possibility of postural orthostatic hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Potassium depletion is unlikely at the recommended dosage, but if it occurs, adjust dosage or withdraw or provide added natural food sources of potassium; potassium tablets should be avoided wherever possible, as bleeding or obstructive ulceration of the small bowel has been associated with their use; potassium levels should be especially watched if the patient is on digitalis or steroids, or if hepatic coma is impending.

PRECAUTIONS: When determining the antihypertensive effect of Eutron, blood pressure should be measured while the patient is *standing*. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Pargyline has not been shown to cause damage to body organs or systems. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. The drug should be used with caution in patients with liver dysfunction. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

Elevated blood urea nitrogen, serum uric acid or blood sugar are possibilities attributable to the methyclothiazide in Eutron. Methyclothiazide may also reduce arterial response to pressor amines. Blood dyscrasias, including thrombocytopemia with purpura, agranulocytosis and aplastic anemia, have been seen with thiazide drugs.

SIDE EFFECTS: The use of pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve. Nocturia has been observed with the combination. If side effects persist, despite symptomatic therapy or reduction of the dose, discontinue the drug.

ABBOTT

512214



Editorial COMMENT

YOUR MONEY'S WORTH

"The American Medical Association, since its founding here in Philadelphia 118 years ago, has matured into a dynamic and vital force in the affairs of this nation. Its numerous and varied programs affect the lives of all citizens of this country and millions of other people around the world."—Thus spoke Dr. F. J. L. Blasingame, Executive Vice-President of the AMA at the meeting of the House of Delegates this past December.

That an increase in AMA dues is seriously contemplated is a well known fact. To this observer, the House of Delegates was in a mood to cause the increase effective as of 1966. This was not done because the delegates wished the opportunity to carry the matter to every physician member in the nation. In most large organizations certain members are always quick to complain and slow to praise the executive functions of the group. There is, however, always less complaint when the membership has all the facts. Concerning this proposal to increase dues, the membership must be informed. The membership must decide whether a fully effective AMA shall continue to function or whether American physicians will depend upon a socialistic federal congress and a near fascist federal bureaucracy to order their lives and the health of the world.

No one has stated the facts concerning AMA more accurately and comprehensively than did Dr. Blasingame in his address to the House of Delegates assembled in Philadelphia. The opening paragraph of this editorial should suffice in selling AMA to physicians and to the nation. But such is not the nature of all. The cautious require facts. The selfish require selling. Such it has ever been before and after Moses came down from Mt. Sinai. The following quotations are taken from the address of the good Executive Vice-President.

"We are short of perfection. . .but overall, the system has worked well toward improving our performance.

"An astonishing variety of talent is required to run an organization like the AMA . . .lawyers. . .accountants. . .physicians. . . chemists. . .economists. . .journalists. . .radio and television experts. . .linguists. . .librarians . . .statisticians. . .computer experts. . .educators. . .businessmen. . .hospital administrators . . .and others.

"The AMA is of such a nature, and its commitment to medicine and the public health is so great, that it cannot escape new and larger responsibilities. The interests and activities of the Association are widespread. All are important. . .and some are vital. . .to the health of the nation and its well-being.

"Many times, I have a feeling of frustration trying to explain the AMA fully. . .and attempting to describe the multitude of programs in which the Association is active. As you can see, I am forced to be selective. You are seeing a list of 80 separate programs." (The 80 were listed on the screen by projection.) "All of them are current, and the list is incomplete. Air pollution. . .drugs. . .environmental health. . .VD. . .industrial health . . .foods and nutrition. . .quackery. . .communications. . .research. . .medical education and health education. . .the list is huge.

"An examination of some of these programs in more detail illustrates how well the AMA is capable of performing.

"DRUGS—The Department of Drugs is the largest of the AMA departments. The scope

(Continued on Page 592)

of its activity is so large that it has become identified as the 'TOTAL Drug Information Program.'

"This program. . . is still developing. . . but it has already gone far toward its ultimate objective. That objective is two-fold: First, to have available. . . or quickly retrievable from the AMA data processing center. . .ALL information on drug therapy on all drugs in use, or which may be used, and, second, to disseminate that information as promptly as possible to physicians and others who have need for it, through all channels of communications available.

"The need is obvious. The value to physicians. . .and to their patients. . .is immeasurable.

"MEDICAL EDUCATION—The quality of medical education has been an area of continuing concern of the AMA since its founding. If medical education in the United States is superior. . .and there is abundant evidence that it is. . .a major share of the credit must go to the constant zeal of the AMA to make it better.

"The fact that 10,000 foreign physicians are training here is one measure of the quality of medical education in this country.

"Our extensive recruitment program. . . with booklets, films, pamphlets, exhibits, and speakers. . .encourages talented young people to choose medicine as a career. We are now receiving 600 to 800 inquiries a week from students interested in becoming doctors. Medical school applications and enrollments are at a record high.

"Once the choice is made and the career launched, needed financial assistance is available through *another* AMA activity. . .the phenomenally successful medical education loan guarantee program, administered by the AMA Education and Research Foundation. In 3½ years, 25,000 bank loans have been guaranteed for 15,000 students, interns and residents. The principal amount of these loans totals more than 31 million dollars.

"Physicians have contributed approximately 40 million dollars to medical schools in the past decade, directly or through the Foundation.

"HEALTH EDUCATION—The American people have an insatiable appetite for information about health. Every year, millions of words on health subjects are published in magazines and newspapers and spoken over radio and television. . .and from other public platforms. Books are written on health. Schools teach it. Radio and television programs. . .both fictional and factual. . .are based on it. Civic clubs, business organizations and farm groups hold meetings about it. Legislators ponder the subject. Physicians discuss it with their patients.

"Never have the people been so well informed about good, and bad, health practices.

"The AMA health education armamentarium includes hundreds of pamphlets. . . a letter answering service. . .news releases. . . exhibits. . .Today's Health magazine. . .a weekly health column for newspapers. . . magazine articles. . . special services to science writers. . .public service spots for television. . .health tips and health programs for radio. . .posters. . .films. . .speeches . .a 50-year-old co-operative program with the National Education Association. And we recently published "Today's Health Guide," a 624-page compendium of health information for the American family. We have already sold 156,000 copies.

"We distribute almost 5½ million pamphlets a year. Our pamphlets, films and other materials are used as teaching guides in schools throughout the country. Today's Health magazine has a circulation of almost 800,000.

"We strive for accuracy, objectivity, dependability and quality. Our performance is not flawless, but our films and publications do win awards. . .

"MEDICINE AND RELIGION—The AMA

(Continued on Page 594)

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HEMOGLOBIN, GLUCOSE, CHOLESTEROL, BUN, URIC ACID



If you are interested in performing the five basic blood chemistries. **With** . . . Only a few seconds working time per test. **With** . . . Results in thirty minutes or less. **With** . . . The accuracy that only a colorimetric procedure can give you. **Without** . . . An increase in personnel. **Without** . . . Making room for bulky equipment. **Without** . . . Training Problems.

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program on medicine and religion, established by the House of Delegates, is in its infancy. . .but the response has been dramatic. It was designed to bring physicians and clergymen together to promote understanding of their respective roles in the care and treatment of patients.

"The AMA cannot expect to be all things to all people, but it must continue to strive to be representative of all the physician population. . .the practitioners. . .the academicians. . .the medical administrators. . .the young. . .the old. . .the "left" and the "right." It must serve as a forum for discussion and decision. It must originate and carry out effective programs that serve the interest of the profession and the general population. It must be capable of reacting promptly to developments within medicine. And it must be a responsible organization so that it can continue to be influential in the affairs of the country as they affect health and medicine.

"Careful attention needs to be given to strengthening our federation. If the Association is to be effective nationally, it must be effective locally. The state and local societies are the critical foundation of the federation. I am sure we would like to see the day when every society was looked to by the people in the community as a principal source of leadership in health. . .as a fountainhead of varied programs and activities involving physicians and laymen working together for the public good.

"My conviction that mature and intelligent leadership is demanded of us as never before was reinforced by attendance at the recent White House Conference on Health.

"As the conference unfolded, it became increasingly apparent that a triumvirate of forces is agglutinating to mold and shape the pattern of health care in this country. This triad includes the federal government, the university-medical school complex, and the hospital system. It is a powerful combination, gaining strength from the millions of dollars of federal funds available to these institutions. . .and given impetus by new laws that have been enacted. . .Medicare. . . the regional medical program. . .and aid to education, which includes grants for institutional use as well as research.

"This coalescence of forces has enormous potential for drastically altering the pattern of medical education, research, and service.

"Organized medicine will always be confronted with problems. They should be viewed. . .not as troubles and vexations. . .but as opportunities. The quality of our leadership may indeed be judged by how well we translate problems into effective programs . . .how well we translate our mission. . .to promote the science and art of medicine and the betterment of public health. . .into programs which meet the demands of a modern, changing world.

"In 1902, AMA was an organization with an estimated 12,000 physician members and a budget of approximately $70,000. Today, the Association pursues a multitude of activities with a budget exceeding 26 million dollars, employs more than 900 people and counts more than 209,000 physicians on its membership roster."

Doctor, your need for a strong and growing AMA has never been greater. Your contributions through AMA to better health for the nation and the world should be more than sufficient compensation. This is not the "Great Society" telling you what to do. This is the greatest Medical Association in the history of the world doing for you and advising you what to do for the better health of each free man and for the untold millions yet unborn.

Doctor, you get your money's worth.

W. L. S.



this part for diarrhea

Kaolin exerts a demulcent action along the gastrointestinal tract and a detoxifying action in the intestines to diminish irritation of the mucosa and lessen hyperperistalsis, nausea and diarrhea.

Pectin exerts its demulcent effect in the entire tract and its detoxifying action primarily in the large bowel to diminish irritation of the mucosa and help restore normal intestinal flora and function.

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Belladonna alkaloids as in Donnatal® relieve hypermotility of smooth muscle in the gastrointestinal tract to help control cramping, nausea, and painful straining. Many clinicians consider the belladonna components of Donnagel® to be medicine's most effective depressants of intestinal motility.[1,2] A preparation containing only kaolin and pectin, on the other hand, has "little or no effect on cramps simply because it does not include an agent with antispasmodic action."[3]

Donnagel® treats the whole diarrhea problem.

Available in new 4-ounce plastic bottle on your prescription or recommendation. Also available: Donnagel®-PG (with paregoric equivalent) and Donnagel® with Neomycin. See product literature before prescribing.

References: 1. Kramer, P., and Ingelfinger, F.J.: Med. Clin. N. Amer., *32*:1227, 1948. 2. Hock, C.W.: Clin. Med., *8*:1932, 1961. 3. Winfield, I.W.: Am. J. Gastroent., *31*:438, 1959.

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COUGH SUPPRESSANT		●	●
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in each 5 cc. teaspoonful:
Glyceryl guaiacolate 100 mg.
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new, non-narcotic
in each 5 cc. teaspoonful:
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OUR PHOTO:
Engine No. 89 of the Monadnock, Steamtown & Northern Railway pulls a trainload of steam enthusiasts through the New England countryside between Bellows Falls and Chester, Vermont.

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ONE OF THE ROBITUSSIN® FORMULAS

NOW IT'S TIME TO PAY THE PIPER

By this time, Americans both young and old have had an opportunity to taste the sweet and/or bitter fruits of Medicare (PL 89-97).

For the young man, particularly if he happens to be married with a family, he has already started counting the cost in increased withholding from his salary to pay for a program of medical care for which neither he nor his family can benefit until they reach the statutory age of 65.

Public Law 89-97 places the young wage earner in the unfavorable financial position of having to pay, throughout the span of his working years, for a health care benefit denied to him and his family. If he wishes to enjoy the same protection offered without charge to the over-65 age group (regardless of their financial holdings) then he must go forth into the open insurance market and buy it for himself.

This was a pitfall of the King-Anderson Medicare bill which never was emphasized by the socialistic planners and, had it not been for the American Medical Association and the state associations, it never would have been called to the attention of the American citizenry.

Once organized Medicine exposed this double insurance booby trap, support for socialized medicine wavered and then dropped into a sharp decline. It finally passed by a margin of less than two dozen votes—shockingly few for a measure which enjoyed the fullest support of an Administration swept into office by a landslide.

It will be interesting to observe how the working man finally reacts to a socialized medicine scheme borne entirely on his own shoulders but forever denied to him unless he is lucky enough to escape fatal accidents and illnesses to reach that suddenly magical age of 65.

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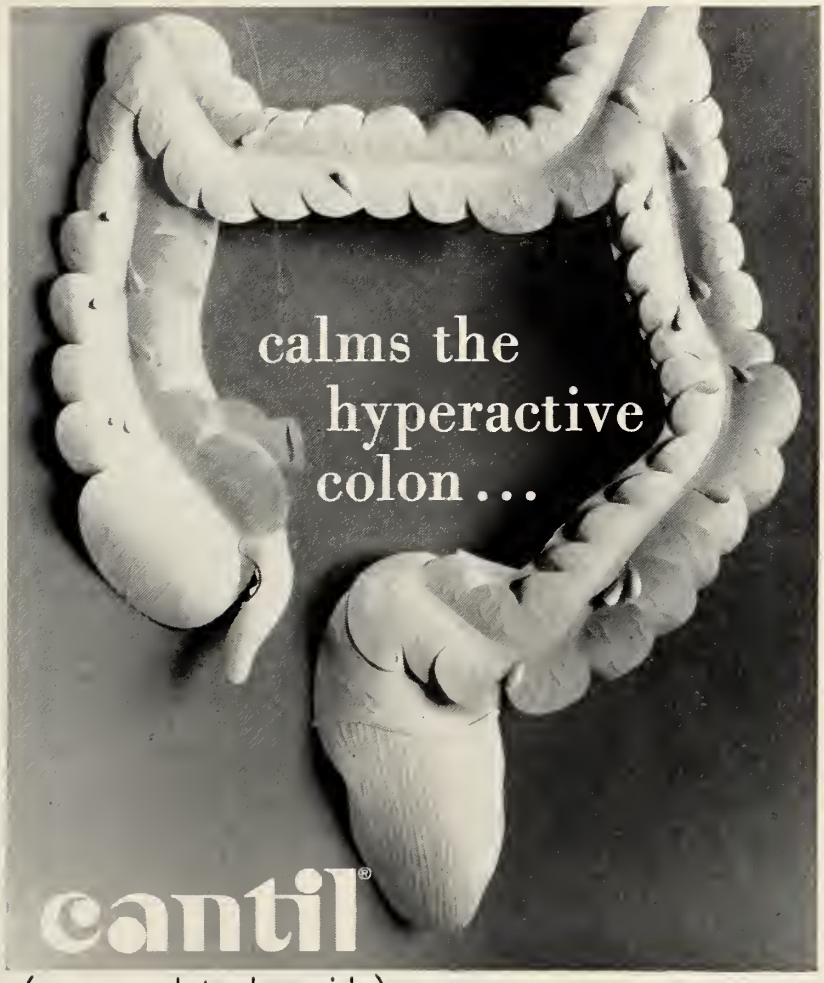
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APRIL 21, 22, 23

NEW TWISTS TO OLD MYTHS

Some folk beliefs about the use of plants as home remedies need to be reviewed to prevent accidental poisonings. A recent description of the severe suffering of an adult woman who had bitten off a stem of Dumb Cane (*Dieffenbacchia*) suggests that all house plants and others not commonly used as food be considered suspect. Also included with *Dieffenbacchia* in the elephant ear group are the well known *Philodendron, Caladium,* and *Colocasia.* Other plants which contain high concentrations of toxic substances are the night shade, poppy, amaryllis, the easter lily and others of the lily family. Such plants as the chokeberry, linseed, Christmas berry, foxglove, corn cockle, and Colorado rubberweed should also be admired only, not eaten. Similarly maintain a high regard for the esthetic qualities of the hollyhock, march marigold, the trumpet creeper, and snow on the mountain but ignore the culinary possibilities. Although birds and animals may eat some of these plants, this does not make them safe for man. In the home, plants should be kept out of reach of children and infants. Seeds, bulbs, and other roots saved and stored for replanting should also be kept away from children. The increase in poison control centers makes it possible, when one has moved into a new area, to obtain information from the local center on suspect plants in the vicinity. (Shirley B. O'Leary: "Poisoning in man from eating poisonous plants," *Archives of Environmental Health,* August 1964).



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1-Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.



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Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

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Dr. Champ Lyons

The Effect Of Champ Lyons On Medical Education In Alabama

Tinsley R. Harrison, M. D.

As compared to men, organizations and institutions have long lives and short memories. But neither the profession nor the Medical Center will forget Champ Lyons.

When, abandoning excellent opportunities in New Orleans and declining academic posts of distinction in a number of institutions, Dr. Lyons returned in 1950 to Alabama as its first full-time clinical teacher, the outlook was anything but propitious. The wounds within the state profession, resulting from the recent strong differences of opinion concerning the location of the Medical College were as yet unhealed. The long-term dissension within the Birmingham profession was still at its high point. Some held the view that the development of the clinical departments would be determined mainly by favoritism and politics, rather than by consideration of academic quality. Others, less cynical, were naturally apprehensive, in the light of experience at other schools, that the new surgical chief would be primarily concerned with the development of a large and remunerative private practice rather than with teaching.

The preclinical teachers were divided. Some realized the inevitable benefit that would come from the increased student interest in the basic sciences consequent to the strong emphasis by a clinician, himself steeped in microbiology, chemistry and physiology, on the practical significance of these sciences in the care of patients. But others, with less vision, were fearful of the glamor of clinical teaching and felt that their own security, in terms of space, budget, curricular hours, was threatened by full-time clinicians. Those who believed that the placid stream of academic apathy might be disturbed by the turbulence of this new current were not to be disappointed.

The chiefs and staffs of the other clinical departments were not immune to similar misgivings. Although recognizing the need for at least a central core of full-time faculty for the larger clinical departments, the volunteer teachers, many of whom had made large sacrifices of time and income for the school, were apprehensive for the future of their own departments. This was especially true of some of the "ologies" which, being headed by young and vigorous chiefs, had managed to secure for their specialties unusual prominence in terms of curricular hours, committee assignments, allotment of teaching beds, and of residency staff. The older clinical chiefs were naturally influenced by their own experience as students three or even four decades earlier. They, therefore, assigned bedside teaching to their juniors and commonly limited their own activities to the lecture room. It was natural that these elder statesmen should look askance at a much younger man whose educational philosophy was so different from their own.

These reflections do not signify any widespread enmity, or even opposition, toward the new chief. There was friendliness and strong support from some, but the more prevalent attitude was that of doubt and uncertainty. No one who is familiar with the long story of the schisms that have so often occurred between medical schools and the local pro-

(Continued on Page 604)



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Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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fessions or who realizes that, in many instances, the main fault has been that of the schools, should be critical of this "wait-and-see" attitude that Dr. Lyons encountered. But it, too, played its role in making him a lonely man during those initial months.

A somewhat similar although less pronounced period of uncertainty is the usual fate of any new full-time clinical chief. His natural reaction to it is an intensified association with his junior colleagues—the students and house staff. But here, too, there were frustrations. The students in 1950 were nearly all veterans receiving their education under the "GI Bill." Although more mature and more serious than the students of earlier and later eras, they had larger families and wider responsibilities. Their natural desires to become permanently settled, with economic stability, were strong deterrents to prolonged residency training. Their family obligations fitted well with the then customary eight-to-nine hour period in the class rooms or clinics, and were in opposition to the 24-hour-a-day, seven-day-a-week responsibility for patients which Dr. Lyons regarded as the *sine qua non* of good clinical education. It is not surprising that during this period the new chief, although highly respected as a surgeon and warmly admired as a teacher, was far from popular as a man.

But even these problems of people were relatively minor, compared to other difficulties. There were no funds for even a minimal junior full-time surgical staff and, in any case, no place to put these much needed persons. The total space available to the Department of Surgery consisted of a small office for the chief and a cubby hole for his secretary. Even more serious, were the financial and administrative aspects of the University Hospital, then known as the Jefferson-Hillman Hospital.

Upon the advice of his own former chief, Dr. Churchill of Harvard and of the Massachusetts General Hospital, Dr. Lyons had made a fundamental decision. This was to develop his department in three successive stages, during which first patient care, then teaching, and finally research were to have priority. Only when one objective had been reasonably well achieved was the next to receive strong emphasis. Here, we need not be concerned with the wisdom of that basic decision—there is much to be said on both sides of such a complex question—but only with its obvious implication that the first step involved the maturation of a then sadly deficient hospital into a first-class institution.

To say that the Jefferson-Hillman Hospital —as the present University Hospital was then named—was grossly inadequate for teaching is not to be critical of any individual. First-class work in radiology and in the laboratories is impossible without a sufficient number of well qualified persons. Good nursing requires a salary scale sufficient to compete with other institutions for quality and quantity of personnel. No too-small administrative team can administer effectively. Efficient service for food and other necessities requires efficient transportation, which was not—and still is not—available. Understaffed and underpaid housekeeping personnel cannot be expected to provide a clean building. No matter how dedicated the house staff and voluntary visiting staff may have been, it was physically impossible—because of the limitations in ancillary services —for them to provide that high standard of patient care which is the fundamental requirement of a teaching hospital.

Granting that some of these deficiencies may have been due to inertia and even to slothfulness, the more basic cause was economic. The hospital was heavily in debt and the pressing need for superior patient care was not to be realized until nearly a decade had passed.

A man of less dedication and courage would either have forsaken the task or, yielding to the current, abandoned the concept of teaching by example. The easy solution would have involved discarding bedside teaching as hopeless under such adverse circumstances

(Continued on Page 609)



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References: 1. Roberts, C.E., Jr.; Perry, D.M.; Kuharic, H.A., and Kirby, W.M.M.: Arch. Int. Med. *107*:204 (Feb.) 1961. 2. Dowling, H.F.; Lepper, M.H., and Jackson, G.G.: Clin. Pharmacol. & Therap. *3*:564 (Sept.-Oct.) 1962. 3. Editorial: Antibiotics & Chemother. *11*:427 (July) 1961. 4. Baer, R.L., and Harber, L.C.: JAMA *192*:989 (June 14) 1965.

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and salving one's conscience by one or two hours daily of personal class-room teaching. It would also have been the popular solution because the students would have been entertained by an excellent showman and would have been freed from those round-the-clock responsibilities which they initially resented.

But Champ Lyons was not one to seek easy or popular solutions. His barque travelled best when pointed upstream. If the hospital, as then constituted, was incapable of providing a high standard of patient care, there was only one answer. He would supply it personally. And he did!

His example gradually spread. Seeing the Chief in the operating room and on the wards at all hours of the day and night, during week-ends and holidays, supplied the catalyst then much needed by the residents, interns and students. Soon they, too, were willing to forego social engagements and rest periods. A new attitude came upon the scene and a new tradition was born.

During the succeeding sixteen years, the graduates of the medical school and, perhaps especially, the members of the surgical house staff have tended to exhibit certain characteristics. The "boys" have not always been outstanding in written examinations, although, here too, the record has been noteworthy during recent years. But it has been in "bedside know how," and in a deep sense of responsibility for patients that Dr. Lyons's pupils have been outstanding. Their record, in competition as interns and residents in many hospitals with graduates of older and better known institutions, has been like that of Sparticus in the arena of Rome. They, too, have not had to lower their arms.

The example of Dr. Lyons affected all of the medical students. But his influence was strongest on those who had the most prolonged association with him—the surgical residents. Many of them are now practicing in various communities in the state and, unless the grapevine is in error, they, too, are outstanding in the combination of medical science, surgical art, and dedication to patients. The beams of these secondary candles originally ignited by a single fire thus have radiated to an entire state.

We are not concerned here with Dr. Lyons's many distinctions as a surgeon, investigator or medical statesman. Perhaps one of his pupils will some day record those achievements for future generations of medical students. Our present topic—his accomplishments as a teacher may be summarized in a few words:

Champ Lyons believed that medicine is a respectable branch of biologic science and a noble art. But he held it to be more than that—a priesthood, too. He taught by example. He practiced what he preached. He lived his own philosophy. We "shall not look upon his like again."

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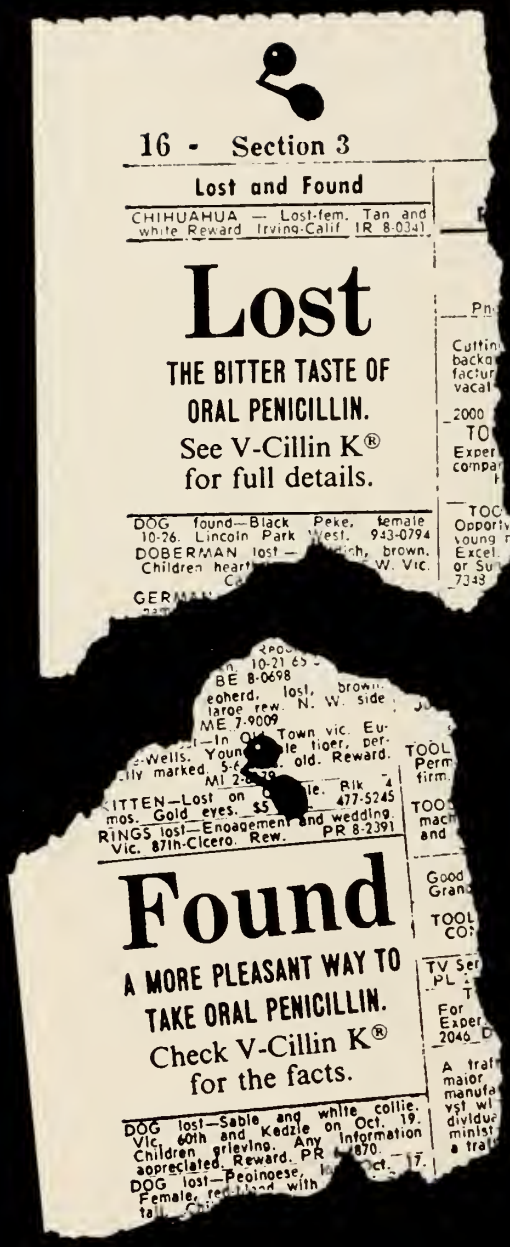
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Small Bowel Tumors: Report Of Four Cases[1]

Dabney H. Brannon, M. D.[2]

There has been steadily increased attention focused on small bowel tumors during the past 30 years. The number of cases reported has dramatically increased, and comprehensive studies are appearing in the literature with increasing frequency. Certainly more of these tumors are being detected through greater awareness and improved techniques. Nevertheless an actual increased incidence cannot be denied. From three to six per cent of all gastrointestinal neoplasms are estimated to arise in the small bowel. On a 46 bed general surgical service, small bowel tumors were encountered on four separate occasions during a two month period (February 5, 1964—April 21, 1964). The purpose of this paper is to report this unusual incidence of this neoplasm which apparently is not so rare as it is generally believed.

Small bowel tumors characteristically produce vague symptoms of relatively long duration. The average duration of symptoms preceding diagnosis is usually in the neighborhood of ten to 12 months. A long history of recurring intermittent symptoms is not uncommon. Bleeding or obstruction or, less commonly, perforation account for the presenting symptoms over 90 per cent of the time. Pain is present in approximately 50 per cent of symptomatic lesions, and a change in bowel habits with tendency toward diarrhea is probably the next most common specific symptom. A palpable mass is present in approximately one-third of the symptomatic cases. A review of the literature reveals that malignant small bowel tumors are almost as common as the benign variety. By far the majority of symptomatic small bowel tumors are malignant. The benign variety are usually diagnosed as incidental findings at operation or at autopsy. In one of the larger series reported, almost as many small bowel tumors were discovered at autopsy as were found at operation. The most common of the malignant neoplasms are adenocarcinoma, leiomyosarcoma carcinoid and lymphoma. Occasionally the benign and malignant varieties of the smooth muscle

1. From the Surgical Service of the Veterans Administration Hospital, Montgomery, Alabama.

Published with the approval of the Department of Medicine and Surgery of the Veterans Administration. The statements and conclusions expressed by the author are the result of his own studies and do not necessarily reflect the opinion or policy of the Veterans Administration.

2. Staff Surgeon, Veterans Administration Hospital, Montgomery, Alabama.

tumors are discussed together because of a recognized difficulty in distinguishing these two types histologically. Characteristically the leiomyosarcoma and carcinoid are prone to produce chronic recurring symptoms over a long period of time, while the adenocarcinoma and lymphoma follow a more acute course. The occurrence of second primary malignancies associated with small bowel tumors has been emphasized in the literature. Although over 60 per cent of all sarcomas involving the gastrointestinal tract arise in the small bowel, the most common primary malignant tumor of the small bowel remains the adenocarcinoma. In spite of the increased attention small bowel tumors have received, the prognosis has remained poor.

Case Reports

No. 1 HHS (06917) A 58 year old white male was hospitalized with a history of epigastric pain and vomiting for eight months, and an estimated weight loss of 50 pounds. The patient had been treated on a peptic ulcer regimen without improvement. There were no symptoms of bleeding. Upon admission there was severe dehydration and hypochloremic alkalosis. Bile stained material was obtained by gastric suction. Gastric analysis revealed no hyperacidity. Barium X-ray studies revealed complete obstruction in the third portion of the duodenum. Exploration revealed an obstructing annular carcinoma of the terminal portion of the duodenum at the ligament of Treitz. Resection was carried out. However, there was evidence of extension of tumor into the adjacent root of the mesentery which could not be removed. Histologic examination (Illus. 1) showed the tumor to be well differentiated adenocarcinoma penetrating the full thickness of the bowel wall and invading serosal fat; an adjacent mesenteric lymph node was not involved. The patient made an uneventful recovery and upon examination 12 months later was completely free of symptoms having gained 40 pounds since his operation.

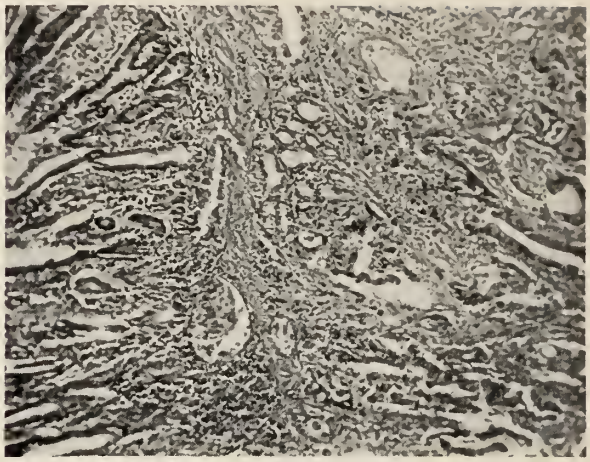


Fig. 1. Adenocarcinoma Duodenum

No. 2 HH (06968) A 69 year old white male was hospitalized because of cramping abdominal pain for three months with associated weight loss. A tender mass, five inches in diameter, was present in the right lower quadrant. Barium X-ray studies of the small bowel disclosed a filling defect in the area of the mass communicating with the small bowel. Exploration disclosed advanced lymphosarcoma of the terminal ileum (Illus. 2) with a walled off perforation constituting a large right lower quadrant abscess. Smaller tumor masses were scattered throughout the small bowel, and the mesenteric lymph nodes were extensively involved. A palliative resection was carried out, and plans were made for postoperative radiation therapy. However, the patient suffered a stroke postopera-

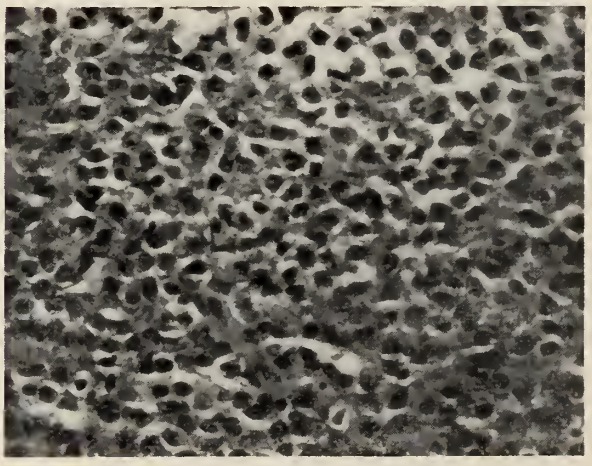


Fig. 2. Lymphosarcoma, ileum

tively, developed a fecal fistula, and expired 32 days after operation. There was no autopsy. Repeated studies of the peripheral blood had been negative for any leukemic change.

No. 3 WLP (07134) A 69 year old white male was hospitalized with a three day history of tarry stools. There was past history of a similar episode in 1957, at which time the patient had received three pints of blood. The cause of bleeding at that time was undetermined. The interval history, as well as review of systems, was negative except for an occasional episode of indigestion. The only complaint upon admission was the presence of tarry stools with associated weakness. There was no history of hematemesis. Physical examination upon admission was not remarkable with the exception of pallor and the presence of tarry stool in the rectum. Hemoglobin was six grams. Gastric analysis showed a significant hyperacidity with histamine stimulation. Barium X-ray studies of the upper gastrointestinal tract were negative. The patient was prepared and taken to surgery with a preoperative diagnosis of bleeding peptic ulcer. At surgery the stomach and duodenum were found to be normal; however, examination of the small bowel revealed a 5 cm. tumor mass projecting from the antimesenteric border of the small bowel half-way between the ligament of Treitz and the cecum. The tumor was resected and subsequently found to be a leiomyosarcoma (Illus. 3). The regional lymph nodes were negative. Convalescence was uneventful, and upon examination nine months later he was entirely free of symptoms, having gained ten pounds since his operation.

No. 4 RW (04369) A 44 year old colored male with neurofibromatosis had a chronic duodenal ulcer complicated by repeated episodes of hematemesis and melena of several years duration. Following a recent bleeding episode while on a medical regimen the patient was again hospitalized and subsequently prepared for elective surgery. At surgery there was found marked duodenal deformity consistent with advanced peptic ulcer disease, consequently a vagotomy and gastrojejunostomy were carried out. Noted incidentally were numerous subserosal nodules varying from 5 to 10 mm. in diameter scattered along the antimesenteric border of the proximal one-half of the small bowel. Histologic examination of representative lesions revealed leiomyoma with atypical cellular changes (Illus. 4) prompting the pathologist to render a guarded prognosis. The patient was discharged following an uneventful convalescence. Nine months later upon follow-up examination he appeared healthy with no complaints.

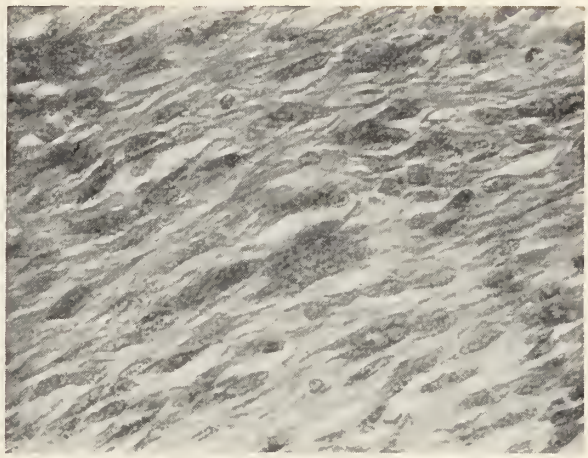


Fig. 3. Leiomyosarcoma, small bowel

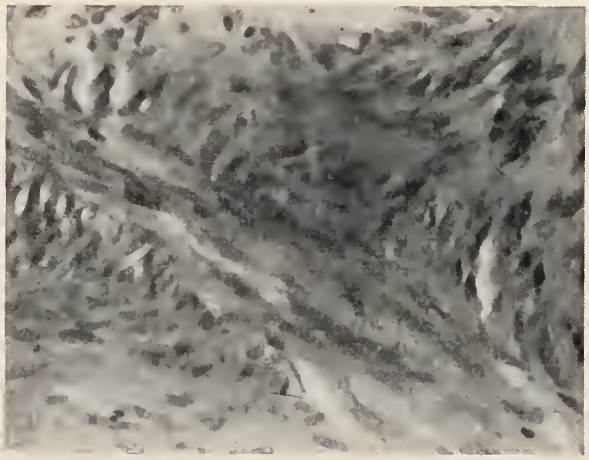


Fig. 4. Leiomyoma small bowel showing cellular atypism

"Patients No. 3 and No. 4 are presently free of disease at two years; patient No. 1 is now terminal with disseminated disease."

Summary

Current reports in the literature indicate an increasing incidence of small bowel tumors. Four cases are reported which were encountered during a ten week period on a 46 bed general surgical service.

Bibliography

1. Sawyer, R. B., K. C. Sawyer, Jr., K. C. Sawyer and R. R. Larsen: Benign and Malignant Tumors of the Small Intestine. Am. Surgeon, 29: 268, 1963.

2. Hunt, Warren H., III, A. C. Brodus, Jr. and Nicholas C. Hightower, Jr.: Primary Neoplasms of the Small Bowel. Southern Med. Jr., 51:482, 1958.

3. Good, C. Allen: Tumors of the Small Intestine. Am. J. Roentgenol, 89:685, 1963.

4. Botsford, Thomas W., Peter Crowe and Diane W. Cracker: Tumors of the Small Intestine, A. J. Surg., 103:358, 1962.

5. Strauch, Gerald O.: Small Bowel Neoplasms, Elusive Source of Abdominal Symptoms. Surgery, 55:240, 1964.

6. Wiancko, Kenneth B. and Walter C. MacKenzie: Primary Tumors of the Small Bowel and its Mesentery. Canada Med. Assoc. J., 88:1225, 1963.

7. Darling, R. C. and C. E. Welch: Tumors of the Small Intestine. New Eng. J. Med., 260:397, 1959.

8. Krause, J. M., R. C. Egerly and J. R. Babcock: Tumors of the Small Bowel. Am. J. Surg., 101:121, 1961.

9. Roehlin, Donald B. and William P. Longmire: Primary Tumors of the Small Intestine. Surgery, 50:586, 1961.

10. Roddy, Stephen R.: Small Bowel Tumors. Arth. Surg., 75:847, 1957.

11. Strohl, E. Lee and Willis G. Diffenbaugh: Primary Tumors of the Small Bowel. Arch. Surg. 74:709, 1957.

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Urinary Catheter Care and Management

Cecil Morgan, Jr., M. D.

Surely almost all of us remember the article which appeared in the New England Journal of Medicine, "The case against the catheter" by Dr. P. B. Beeson wherein he condemned the use of the catheter because he felt it invariably introduced bacteria which led to pyelonephritis and serious, if not fatal, renal damage.[2] We must all take his comments seriously, but urologists and other physicians necessarily find themselves daily inserting and manipulating catheters, thus they must rationalize their use against their inherent dangers. Indeed, almost all physicians at one time or another work with patients or situations where urinary catheters have been involved, and they all share the responsibility of not harming the patients with the use of the catheter. It is the purpose of the following paragraphs to aid somewhat in the discharge of this responsibility.

Individuals with normal urinary systems void urine almost as sterile as boiled water, and there seem to be two major factors that aid the bladder in resisting infection. First of these is simply mechanical, and that is the complete and repeated emptying of the bladder by voiding. The second is the documented but poorly understood intrinsic resistance of the bladder mucosa to the establishment of bacterial infection. The urine itself has no properties for inhibition of bacterial growth. Thus, in the non-obstructed bladder, colonies of *E. coli* can be artificially instilled in normal volunteers and within a period of hours, on no medication, the urine will become free of infection.[3] However, if either one or both of these mechanisms is altered, persistent infection easily occurs.[3,6] Thus, it follows that any patient requiring urinary catheterization has alteration of his protective mechanism, and it is encumbent on the physician to do all that is humanly possible to protect this vulnerable bladder from contamination.

It has been demonstrated many times that meticulous catheter care can minimize or prevent urinary infection,[1-5] whereas, neglected catheters quickly lead to infection, stone formation, and pyelonephritis. The first step in proper care begins with insertion of the catheter. Every possible effort must be made to insure that an aseptic technique is used, but the by-word at this stage is gentleness, for—as is the case elsewhere in the body—trauma predisposes to infection. The second step is the choice of catheters. This plays an important role because the use of the smallest effective catheter is associated with the least urinary infections. Specifically, in males this would be a size 16 French. Smaller catheters would not drain well enough. In females, size 18-20 French catheters are satisfactory as the size of a normal adult female urethra should accommodate size 30 French with ease. Seven to ten ml. of sterile water should be used in the 5 cc Foley balloon which often falls out because of inadequate filling. The time of original catheterization is the most effective opportunity for collection of urine specimens for both culture and microscopic examination. Also the amount of urine in the bladder should be measured and recorded as it has therapeutic pertinence. The over-distended

From the Department of Surgery, Division of Urology, Medical College of Alabama, Birmingham.

Presented at a Seminar on Urology, sponsored by the Division of Continuing Medical Education, Oct. 1, 1965.

bladder will need longer drainage to regain detrusor tone so that residual urine will not occur.

Catheters should be drained with as large a tube as is feasible to offer the least peripheral resistance. The 9/32 in. plastic disposable tube available from many companies is the most ideal at present. This drainage tube must then be emptied into a *sterile* container. By far the most effective system is the closed drainage system with filtered air escape ports on the collection receptacle, but for routine hospital care the easily obtained disposable semi-closed system is more practical. Indeed Pasteur demonstrated that an open drainage receptacle will be contaminated with bacterial invasion within 48-72 hours.

The urine container itself is the first of three ports of entry for bacteria into the catheter system. Some investigators have advocated keeping a 10 per cent formalin solution inside the containers to minimize infection, but the use of the semi-closed system, and reasonable frequent changes of receptacles represent the most practical method of caring for the collection receptacle. It is important to emphasize that the drainage tubing should never be under the level of the urine in the drainage receptacle. It must be assumed that the urine is, or potentially is, infected and this would allow direct contact through the drainage tubing itself. If the container is raised above the level of the bladder, and the tip of the drainage tube is below the level of urine, a syphoning effect can occur, delivering markedly contaminated urine into the bladder.

The second port of entry is the connection between the catheter and the drainage tubing. This linkage must be broken occasionally for the collection of urine specimen, as well as for irrigation of catheters. During these procedures every effort must be made to minimize contamination of the two ends. When disconnected, the drainage tubing should be wiped with aqueous Zephiran or alcohol and wrapped in sterile gauze. The catheter tip itself should be wiped before and after use. Then prior to reconnecting this linkage, both ends should again be wiped with an antiseptic solution. Never should the drainage tube or catheter be allowed to drain into a bath tub, on the bed or on the floor as so often seen, even in the best hospitals.

The third port of entry is along the outside of the catheter at the urethral meatus. The method for minimizing this is to maintain good hygiene in this area by washing the meatus in both the males and females at least daily, with Zephiran solution, to remove all encrustations and body secretions. After each washing, or at least twice daily, Polysporin, or similar ointment, should be applied around the catheter at the meatus. Naturally, high, adequate fluid intake should be maintained so the urine flow is considerable. Also, unless the urine flow down this tubing is more than 2 ml. per minute, motile bacteria are able to swim up-stream against the current, or certainly spread up the side of the tube. Catheters should be placed *over* the leg and taped to the thigh or lower abdomen to avoid fecal contamination and acute angulation of the urethra in males which can cause fistula formation on long-term usage. Also, on short term catheterization, chemotherapy should be utilized and should be continued several days after the catheter is withdrawn. The urine must then be examined to be sure that no residual infection develops. On long-term catheterization, I personally believe that these patients should also be maintained on urinary antiseptics, sometimes alternating drugs. But in the absence of systemic symptoms, the use of high potency antibiotics while a catheter is in is rather ineffective. Reinfection with organisms which then will be resistant to these high potency antibiotics is a distinct possibility. If systemic symptoms of urinary infection do occur, then these drugs must be used, but to try to clear an infection where a foreign body is present in the

bladder has been recognized by urologists as an almost impossible situation. Thus, it is after catheter removal that efforts are made to completely render urine sterile. In those infected patients requiring retention catheters, our efforts are directed to minimize that infection by keeping bacterial counts as low as possible by large fluid intake (and output) and chemotherapy.

Bladder catheters must be changed at least every four - six weeks. The drainage tubing from catheters should be changed every seven - ten days, and the use of the new plastic sterile disposable tube makes this much more practical.

Patients requiring catheters for only a few days, or even one or two weeks usually do not require irrigation. However, if catheter drainage extends a month or more, daily irrigations are necessary to reduce the possibility of accumulated urinary sediments around the tip of the catheter, resulting later in possible stone formation, infection, and poor drainage. The best solution for this at the present time is ten per cent sterile Renacidin (a mixture of organic acids) and this can be used twice daily. It is not an antimicrobial agent, but it does dissolve many precipitated urinary sediments. It does not dissolve uric acid and cystine crystals.

Proper care and techniques must be used in these irrigations. Solution and containers for irrigations must be sterile; also, the irrigating device itself must be kept uncontaminated during the procedure; thus, if using a barrel type syringe, only by using the gloved hand can these syringes be utilized aseptically. On the other hand, a bulb-type syringe can conceivably be used without rubber gloves, and an aseptic irrigation carried out. For the ambulatory patient, plastic urine leg bags are available at minimal cost. These are quite useful to these patients; however, proper care of the connection tips must be utilized. The margins are narrow. Remember that there is a distance of 18 inches or less between patient's urinary tract and the cause of possible fatal pyelonephritis.

The external or condom "catheter" has considerable use in the incontinent patient to facilitate ordinary nursing care; however, when any of these instruments are applied, it is encumbent upon the physician to know that this is not overflow incontinence resulting from either bladder neck obstruction or neurogenic bladder, and that the patient does not have residual urine which will lead to infection and progressive renal damage. The external "catheters" have to be changed daily, and meticulous care to the skin of the penis must be maintained to avoid slough or excoriation.

Now I have a question for you: Do you allow the clamping of catheters on your patients? I emphatically do not! However, I must admit that it is extremely difficult to keep hospital personnel from doing anything they can to get that tube stopped up. After all, it is the urologists' main goal in life to remove obstruction to the urinary tract. When he has done so by catheter, the last thing he wishes is to have that catheter clamped off, allowing urine to pool in the bladder and infection to progress up a stagnant column of urine in a catheter and drainage tube, thereby defeating the purpose of the catheter itself. If bladder catheters are clamped, so are other catheters. Nephrostomy and ureteral catheters usually are the only outlet for urine from a kidney so when they are clamped, hydronephrosis occurs in minutes.

There is almost no good reason for catheter clamping, the least of which would be for sending a patient from one hospital area to another, or for the collection of specimens, or for the simple convenience of the nursing personnel.

Summary

Thus, in summary, I would like to suggest a re-emphasis on catheter care in all of our institutions. Encourage gentleness, aseptic techniques, closed or semi-closed systems,

adequate drainage, protection of the urethral meatus, attention to properly spaced catheter changes, and daily meticulous care of the indwelling urinary catheter.

References

1. Ansell, J.: Care of urinary retention catheters. Northwest Med. 1965, 64:349-352.

2. Beeson, P. B.: Case against catheter. Am. J. Med. 1958, 24:1-3.

3. Cox, C. E. and Hinman, Jr., F.: Experiments with induced bacteriuria, vesicle emptying and bacterial growth on the mechanism of bladder defense to infection. J. Urol. 1961, 86:739-748.

4. Desautels, R. E.: Aseptic management of catheter drainage. New Eng. J. Med. 1960, 263: 189-191.

5. Martin, C. M. and Bookrajian, E. N.: Bacteriuria prevention after indwelling urinary catheterization. Arch. Int. Med. 1962, 110:703-711.

6. Sunshine, H.: The prevention of ascending pyelitis by the intact ureterovesical junction: an experimental study. J. Urol. 1964, 92:351-357.

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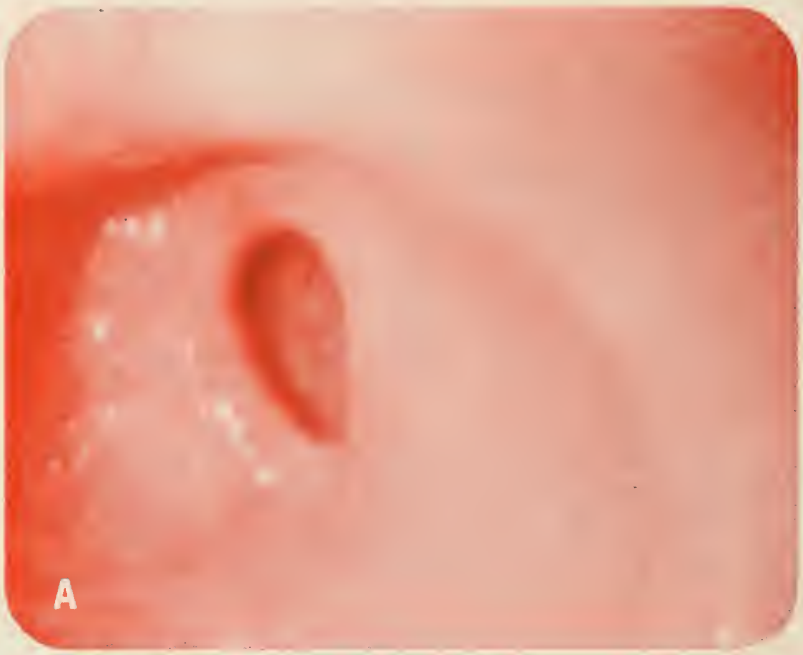
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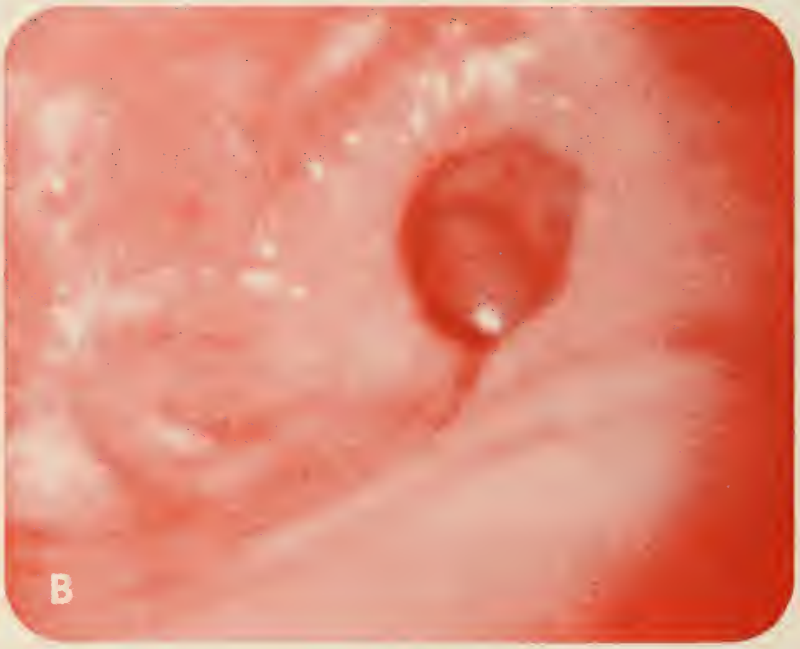
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MIDYEAR REPORT

COMMITTEE ON LEGISLATION

The Committee on Legislation of the Medical Association of the State of Alabama can point with pride to the legislative achievements of 1965 as they relate to the profession of medicine in Alabama.

From early February until late October the Alabama Legislature was in session. First the Governor summoned the lawmakers into a Special Session in early February to resolve the problem of adequate financing for education. This session lasted almost until the opening day of the Regular Session in May. Next there was a Second Special Session, called to enact legislation related to legislative reapportionment, followed by a Third Special Session called to enact a bill permitting a Governor and other constitutional officers to succeed themselves.

While the Medical Association of the State of Alabama had no legislative program of its own this year, it was committed to render full assistance to the Alabama Department of Health in its program to attain additional operating funds and to the University of Alabama Medical College in its several legislative endeavors. It can now be reported that every major medical bill supported by the Association and this Committee has been enacted into law.

FIRST SPECIAL SESSION

Two bills of major importance to Medicine passed by the First Special Session of the Legislature concerned (1) a scholarship bill for medical students and Public Health and (2) a ten million dollar bond issue for the Medical College. Both of these bills passed the Legislature with relatively little difficulty, although at one time it appeared that the bond issue bill would be drastically reduced.

Meeting of April 23, 1965

With the Regular Session of the 1965 Legislature scheduled to convene in just two

weeks, the Committee on Legislation asked for and received special dispensation to meet during the Orientation period of the Annual Session to review and make recommendations on a large number of bills proposed for introduction at that session.

Most important item on the agenda was a request from the State Health Officer, Dr. Ira L. Myers, for support in his program to secure an additional two million dollars in financing for his department. Dr. Myers had addressed his request for funds to the Governor and his budget committee and at the time of this meeting, it was not known whether the increase would be approved. (Note: The request was subsequently reduced to $560,000 and a committee representing MASA appealed directly to the Governor to enlarge the amount. Following the conference it was determined that an additional 1¢ per package tax on cigarettes could be levied and would produce a sum slightly in excess of the two million dollars requested by the Health Department. This law was enacted and is now in effect.)

Dean Richardson Hill of the Medical College of Alabama appeared before the committee at its request to discuss legislation designed to benefit that institution. He explained in detail the plans if the ten million dollar bond issue should be approved, to expand the student body of the college by approximately 25% with an increase of students in the freshman class from 80 to 100 per year. He said the college would construct a basic science building and that the Medical College would attempt to establish a school for training public health officers which would be the only one of its type in the southeastern United States.

Dean Hill told the committee that legislation was needed to permit issuance of certificates of qualification to foreign-born teachers at the Medical College who are not eligible for U. S. citizenship. A three bill package would have been necessary to authorize the Board of Medical Examiners to issue certificates of qualification and to amend the basic science and healing arts laws to make them conform. (Note: These three bills were enacted into law during the Regular Session with a minor amendment which was acceptable to the Medical College.)

Numerous other bills were studied by the Committee during this special meeting. One of them, known as the Battered Child Law, was drafted by the Committee on Legislation at the request of the American Legion of Alabama, which wanted to sponsor it as part of its nationwide program to protect the child from abuse. An earlier bill on this same subject had been withdrawn from the Legislature at the request of the Committee on Legislation because it was not broad enough to adequately protect the child. (Note: The Committee's bill was introduced in the Legislature under the sponsorship of the Alabama Department of the American Legion and was enacted into law without change.)

The Committee discussed a number of other bills including a Good Samaritan Law, a voluntary and eugenic sterilization law, an abortion law, a law to control marriage or family counsellors, and others. In most instances the Committee agreed that the time had not arrived for passage of these bills and that the Committee would continue to study them and to observe their operation in States which have enacted them.

A request by the Alabama Optometric Association for MASA support in a move to amend the State Optometric laws to outlaw chainstore Optometry Departments was considered and approved. (Note: The Optometric Law was amended during the Regular Session to delete Section 210, which was the purpose of the bill.)

1965 REGULAR SESSION

The 1965 Regular Session of the Alabama Legislature convened May 4, 1965, and immediately a deluge of bills directly or indirectly concerning medicine was introduced in both the House and Senate. In the opening days no less than ninety bills of direct interest to Medicine were introduced. This

includes, of course, many bills of identical or almost identical wording introduced in both Houses to take advantage of parliamentary procedures and situations which often move a bill faster through one house of the Legislature than the other. A brief summary of the most important of these bills follows:

Cigarette Tax for Health (House Bill 874)—was introduced June 29, 1965, with support of Governor Wallace and the administration at the request of the Medical Association of the State of Alabama and the State Department of Health for the purpose of raising operating revenue for the Department of Health. It was estimated that the tax would produce approximately three million dollars per year of which 60 per cent would be allocated for general health purposes and the remainder for mental health purposes. The bill was sponsored by Representatives Slate and Moore. It passed the House with an amendment on July 23 and was approved August 6 by the Finance and Taxation Committee of the Senate with an additional minor amendment to the bill. It was given final approval by the Senate with House concurrence in the amendments on August 26 and was signed into law by the Governor on August 30 as Act No. 654.

As long ago as November 2, 1964, the Medical Association of the State of Alabama was committed by a resolution to do all that was necessary to increase the appropriation to the State Health Department. State Health Officer, Ira L. Myers, presented the financial problems to the midyear meeting of the Association held in Montgomery on November 2, 1964, and again at the Annual Session held in Birmingham on April 22-24, 1965. In addition Dr. Myers had made numerous appearances before the County Medical Societies and civic organizations throughout Alabama detailing the critical needs of the Department. He based his hopes for relief on an additional two million dollars in appropriations for the budgetary appropriations money for each of the fiscal years 1965-66 and 1966-67. When the budget was published, however, it was learned that this request had been cut to only $560,000 increase per year. Dr. James G. Donald, President of the Association, obtained an appointment with the Governor for June 15, 1965, and on that date he was accompanied by a large delegation representing the Board of Trustees and the Board of Censors. The Governor was sympathetic and suggested that the Association confer with the administration leaders and the Legislature for the purpose of finding a source of revenue which would produce sufficient funds to meet the needs. House Speaker Albert Brewer who, throughout the proceedings, stood on the side of Medicine, suggested the cigarette tax and assisted in drafting the measure which was eventually presented and enacted into law. It is significant that not a single dissenting vote was cast against this bill in either house including committee considerations. This unprecedented unanimous support of the entire Legislature and the administration will be long remembered by the Board of Health.

Health Department Salary Bill (House Bill 53)—removes limitations on salaries of professional employees of the Department of Health. It was sponsored by Representative Alton Turner, passed the House on June 25 and the Senate on August 13 with the support of Senator Shelton, was signed into law August 19 as Act No. 437.

The legislation to eliminate unrealistic salary ceilings for professional employees of the State Health Department was considered as a "companion bill" to the cigarette tax bill simply because it had been established that trained professional people could not be employed for the salaries being offered at that time. The Association was firmly committed to assist the State Department of Health in removing these salary limitations so that existing vacancies could be filled with competent professional workers. Final passage of this bill was achieved through the assistance of Senator Roland Cooper and Senator A. C. Shelton who took advantage of a brief moment of harmony in the Upper House to bring it up for affirmative action.

Indicative of Medicine's high prestige in the Alabama Legislature is the fact that not one dissenting vote was cast against this bill at any stage of its procedure through the House and Senate.

Mental Health Bill (House Bill 699)—establishes a single department of mental health to combine all present mental health activities in the State, including the Commission on Alcoholism and the Mental Hygiene Division of the State Health Department and to operate all mental health institutions, clinics, and other facilities. The bill was sponsored by Representatives Camp and Bevill, introduced June 16, substituted in the House Health Committee and passed House on August 3, amended in Senate Health Committee August 13, and given final vote of approval in House concurrence on August 26, 1965. It was signed into law by the Governor on September 3, 1965, as Act No. 881.

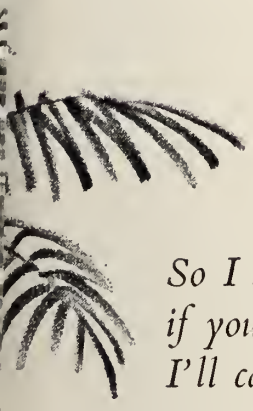
The Mental Health Act of 1965 was the culmination of many years efforts by the Alabama Mental Health Association to divest the Department of Health of this responsibility and to concentrate all mental health activities under a separate board composed jointly of physicians and laymen. The Medical Association of the State of Alabama had objected to divorcement of mental health programs from the public health service and had for many years contested this action. However, in the Regular Session of the Legislature in 1963 it became evident that sentiment for creation of a separate Department of Mental Health was growing and that passage of such legislation to make this possible was becoming more inevitable with each passing session. It was therefore determined by the Association, acting through the Board of Censors, to hold conferences with members of the Mental Health Association to determine whether agreement could be reached on a bill palatable to all conferees and of greatest benefit to the patients affected. Representing the physicians in these deliberations were John M. Chenault, M. D. of Decatur, Paul Burleson, M. D. of Birmingham, and Hugh Gray, M. D. of Anniston. The bill as finally approved created a Department of Mental Health with jurisdiction and supervision of Bryce Hospital, Searcy Hospital, Partlow State School and Hospital, the existing division of mental hygiene, and the existing Commission on Alcoholism. The Department has a 13-member Board of Trustees which establishes policies and has control over all properties. The Department is directed by a Commissioner elected by the Board of Trustees. Of the 13 members on the Board of Trustees, seven are licensed physicians, two of whom are qualified psychiatrists. The Commissioner must be a practitioner of medicine qualified in the specialty of psychiatry. While the Association did not necessarily agree that a separate department of mental health would best meet the needs of Alabama, it accepted the several compromises and agreements as recommended by its conferees and subsequently lent its best efforts to passage of the mental health bill.

Teacher's Certificates for Foreign Doctors (Senate Bill 66 with companion bills 64 and 65)—authorizes the Board of Medical Examiners to issue one-year certificates of qualification to foreign-born doctors employed by the Medical College to enable them to practice medicine strictly within the confines of the College. Identical bills introduced in the House as HB 5, HB 6, and HB 7 were permitted to die on the calendar after passage of the Senate bills. The Senate bills were introduced by Sen. James S. Clark on May 4, 1965, passed by Senate on June 4 and by House on August 19, signed by Gov. Wallace September 1 as Acts Nos. 671, 670, and 669.

These bills were supported by the Association at the request of the Dean of the Medical College and are similar to thase enacted in many other States to permit foreign-born doctors to practice medicine within the confines of the Medical College until they can receive U. S. citizenship and qualify for licensure. The Association's role in this legislation was mainly that of watchdog and of

(Continued on Page 628)





So I said, "All right, Raymond, if you don't take your cough medicine this minute, I'll call Doctor Peabody."

Controlling the child is sometimes as big a problem as controlling his cough. But with most children and with most coughs, the job is usually much easier with one of these effective Novahistine formulas.

If it's the useless, exhausting type of cough that often accompanies respiratory infection or allergy, you can provide prompt relief with Novahistine DH. Its decongestant-antitussive action controls frequency and intensity of cough spasms without abolishing cough reflex. And the fresh grape flavor of Novahistine DH appeals to children and adults alike.

When your diagnosis is bronchitis, complicated by thick tenacious exudates, Novahistine Expectorant is particularly useful. It not only provides decongestive action and controls the cough, but also encourages expectoration, thus easing bronchial obstruction.

Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Ambulatory patients should be advised that drowsiness may result. Continuous dosage over an extended period is contraindicated since codeine phosphate may cause addiction.

Each 5 ml. teaspoonful of Novahistine DH contains codeine phosphate, 10 mg. (Warning: may be habit forming); phenylephrine hydrochloride, 10 mg.; chlorpheniramine maleate, 2 mg.; chloroform (approx.), 13.5 mg.; l-menthol, 1 mg. (Alcohol 5%). Each 5 ml. of Novahistine Expectorant contains the above ingredients and, in addition, glyceryl guaiacolate, 100 mg.

NOVAHISTINE® DH

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DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

(Continued from Page 625)

keeping its sponsors informed as to its progress. Senate bill 64 was amended in the House, but the amendment did not affect the bill.

Water Pollution (House Bill 132 substituting for HB 198 and SB 25)—strengthens control over water pollution. It was a much disputed bill which required numerous compromises before passage by the House on July 13 and by Senate on August 17. It was signed by the Governor on August 26 as Act No. 574.

There are four major changes in the law under which the Commission has operated for the past sixteen years provided for in Act No. 574.

The so-called "grandfather clause" is removed from the existing law placing every person who discharges pollution to waters of the State under the jurisdiction of the Commission.

The new water pollution control Act added a second member representative of wildlife and conservation to the Commission and dropped the representatives, one from the University of Alabama and one from Auburn University. This reduced the Commission's membership from 15 to 14.

The recovery of damages for the loss or destruction of wildlife, fish and aquatic or marine life by pollution of waters is a new feature of the Act.

The Executive Committee of the Commission has been changed by the replacement of one of the two industrial members with a member representing wildlife and conservation. There were also some changes with respect to the responsibilities of the Executive Committee.

Boat Pollution (House Bill 816)—regulates discharge of sewage from watercraft, introduced by Representative Vacca on June 25, passed by House on August 17, approved by Senate Committee on Health on August 19, and defeated in Senate by vote of 15-18. It was the only bill sponsored by Medicine to lose on a roll-call vote.

This bill was introduced by the State Department of Health and proved controversial, especially in the Mobile area. It required installation of pollution control equipment and was strongly opposed by the commercial fishing interests. Misunderstanding of the intent of this bill was doubtless the cause of its defeat.

Advisory Council, State Board of Health (Senate Bill 507 identical to House Bill 1040)—provides for appointment of an Advisory Council to the State Board of Health to conform with Hill-Burton Act regulations, sponsored by Senators Cooper and Clark, introduced in Senate on July 27, passed Senate on July 29, passed by House on August 8, and signed by Governor on September 3 as Act No. 870. Federal requirements specified equal representation of consumers to balance this body resulting in a sizeable increase in the Council members.

Increase TB Patients' Per Diem (Senate Bill 463)—increases State per diem payments for tuberculosis patients from $7 per day to $7.25 per day, introduced by Sen. Harlan Allen on July 13, passed by Senate on July 29, passed by House on August 10, and signed by Governor on August 13 as Act No. 450.

P. K. U. Bill (Senate Bill 9 identical to House Bill 10)—provides for compulsory testing of newborn babies for phenylketonuria, introduced in both chambers on the opening day, passed by Senate on June 15, passed by House on August 26, and signed by Governor on September 5 as Act No. 885.

This was a bill over which the doctors of Alabama were sharply divided. While the P. K. U. bill was not officially endorsed by the Committee on Legislation or the Association, neither was it vigorously opposed. At its meeting on June 5 the Committee on Legislation took cognizance of the introduction of the bill into the Legislature and recommended to the Board of Trustees that mandatory testing for P. K. U. would not be good

for the State and that, furthermore, P. K. U. testing was being done already in a number of hospitals. The State Health Officer appeared before the House Judiciary Committee to explain that P. K. U. testing would cost the Health Department an estimated $45,000 per year and that such funds were not available, but the bill was passed in spite of this argument. The bill carries no penalty clause.

Battered Child Bill (Senate Bill 8 identical to House Bill 114)—provides that doctors, nurses, school teachers, and others having knowledge of abuse of a child shall report to proper authorities; introduced in Senate by Sen. Clayton Carter on May 4, passed by Senate on June 22 and by House on August 19, and signed by Governor on August 26 as Act No. 536.

The Battered Child Bill has occupied much attention of the Committee on Legislation. A bill introduced in the first special session of 1965 by Sen. Carter was withdrawn at the request of the Association because it limited reporting by physicians and did not protect the child from such forms of abuse as malnutrition. The American Legion has called upon all of its State Departments to obtain passage of battered child legislation as a part of its child welfare program. The Alabama Department of the American Legion through Mr. Lawson Lynn called upon the Committee on Legislation to draft a bill which would be acceptable to the physicians of this State and would protect adequately the child. This was done and the bill was introduced in both houses. There later came a request from the Commissioner of Pensions and Security, Mr. Ruben King, to amend the bill to have physicians report to child welfare authorities rather than to police authorities. This amendment was not opposed by the Association but it was never introduced in the Legislature and the bill passed unchanged.

Amend Medical Scholarship Law (House Bill 391)—makes a minor amendment to the Medical Scholarship Law requiring that any moneys repaid from loans to medical students should be returned to the Special Educational Trust Fund from which it came; introduced in House by Rep. Rankin Fite on May 21, passed House July 27, passed Senate August 26, and signed by Governor September 1 as Act No. 752.

Quorum Board of Health (House Bill 55)—makes technical changes in the Board of Health Law; introduced in House by Rep. Alton Turner on May 4, passed by House on August 3 and by Senate on August 26, and signed by Governor on September 2 as Act No. 796.

Amend Medical Examiners Law (House Bill 56)—makes technical changes in the law relating to the Board of Medical Examiners; introduced in House on May 5 by Rep. Turner, passed by House on August 3, passed Senate August 26, and was signed by Governor on September 2 as Act No. 797.

Amend Workmen's Compensation Law (House Bill 97)—permits workers to select their own physician and surgeon under the Workmen's Compensation Law; introduced by Rep. Nabors et al on May 4, substituted and amended in Committee and passed on August 6, approved by Senate Committee on August 17, and died on Senate Calendar.

Physical Therapy Bill (House Bill 8)—regulates the practice of physical therapy, establishes the licensure of physical therapists, and appointment of a Board of physical therapists; sponsored by Rep. Sim Thomas, introduced in House on May 4, passed House on July 14, passed by Senate on August 10 after amended with House concurrence, and signed by Governor on August 20 as Act No. 476.

HOUSE BILLS—FIRST EXTRAORDINARY SESSION

NO.	SUBJECT	SPONSOR	PASSED BY HOUSE	PASSED BY SENATE	GOV. SIGNED	NO. OF ACT
HB 15	Income Tax Deductions for Medical Expenses	Blanton & Vacca	2-26	4-20	5- 5	No. 246
HB 24	$10 Million Bond Issue for Medical College (Same as SB 3)	Rast et al	These bonds were approved in other legislation			
HB 65	Permit Physically Handicapped to Vote Absentee Ballot (Same as SB 16)	Callahan, Bevill and Brown	Died in House Judiciary Committee			
HB 66	Authorize Treatment of Indigent with Chronic Lung Disease in County District Hospital	Callahan et al	2-23	3- 3	3-12	No. 26
HB 106	Authorize Municipalities to Build, Operate Medical Clinic	Pennington et al	with amend. 2-26	Died on Senate Calendar		
HB 182	Medical Scholarship Bill	Fite and Brewer	with amend. 3-24	with amend. 4-29	5- 5	No. 278
HB 212	Amend Constitution to Provide for Mobile General Hospital Tax	McDermott et al	with amend. 3-23	4-30	4-30	No. 237
HB 219	Privileged Communication for Clergymen	Crawford	Died in House Judiciary Committee			
HB 230	Increase Salary of State Health Officer	Turnham, Vacca, and Campbell	Died on House Calendar			
HB 232	Establish Graduate School for Social Workers at University of Alabama (Same as SB 138)	Hannah et al	4-13	Died on Senate Calendar		

SENATE BILLS—FIRST EXTRAORDINARY SESSION

NO.	SUBJECT	SPONSOR	PASSED BY SENATE	PASSED BY HOUSE	GOV. SIGNED	NO. OF ACT
SB 3	$10 Million Bond Issue for Medical College (Same as HB 24)	Gilchrist et al	These bonds were approved in other legislation			
SB 8	Enabling Act For Medical College Bonds	Dumas	Died on Senate Calendar			

SB 16	Permit Physically Handicapped to Vote Absentee Ballot (Same as HB 65)	Evans and James	Died on Senate Calendar			
SB 35	Good Samaritan Bill for Rescue Squads only	Hammond	Died in Senate Judiciary Committee			
SB 58	Require Eye Protective Devices in Vocational Schools	Carter	with amend. 2-26	3-17	Exe. Amend. 4- 5	No. 168
SB 59	Battered Child Bill	Carter	Withdrawn by Sponsor at request of MASA			
SB 112	Establish Meat, Poultry Inspection Laboratories under Dept. of Agri. & Industries	Oden	Died in Senate Finance & Taxation Comm.			
SB 138	Establish Graduate School for Social Workers at University of Alabama	Cooper et al	4-13	4-20	4-28	No. 234

HOUSE BILLS—REGULAR SESSION

NO.	SUBJECT	SPONSOR	PASSED BY HOUSE	PASSED BY SENATE	GOV. SIGNED	NO. OF ACT
HB 3	Pharmacy Practice Act	Thomas	Died on House Calendar			
HB 4	R. N. Nurse Practice Act	Thomas et al	Died in House Ways & Means Committee			
HB 5	Permit Foreign Doctors to Practice at Medical College	Thomas	6-29	Died in Senate Public Health Committee		
HB 6	Amend Healing Arts Law to Conform with HB 5	Thomas	6-29	Died in Senate Public Health Committee		
HB 7	Amend Basic Science Law to Conform with HB 5	Thomas	6-29	Died in Senate Public Health Committee		
HB 8	Physical Therapy Practice Act	Thomas	7-14	with amend. 8-10	8-20	No. 476
HB 10	Compulsory Test for P. K. U.	Merrill et al	5-28	Died in Senate Public Health Committee (Covered by SB 9)		
HB 16	Good Samaritan Bill for Rescue Squads	Meade	8- 3	Died in Senate Judiciary Comm.		
HB 42	Jury Trial in Lunacy Cases	Teel	Died in House Judiciary Committee			

(Continued on Page 632)

HOUSE BILLS—REGULAR SESSION—(Continued)

NO.	SUBJECT	SPONSOR	PASSED BY HOUSE	PASSED BY SENATE	GOV. SIGNED	NO. OF ACT
HB 53	Health Department—Salary Bill	Turner et al	6-25	8-13	8-19	No. 437
HB 54	Venue Hospital Licensure Appeal	Turner et al	Died in House Health Committee			
HB 55	Establish Quorum, State Board of Health	Turner et al	8- 3	8-26	9- 2	No. 796
HB 56	Extend Authority Board of Medical Examiners	Turner et al	8- 3	8-26	9- 2	No. 797
HB 90	Permit Abandonment of Cemeteries for Highway Purposes	Crawford et al	Died on House Calendar			
HB 97	Medical-Surgical Hospital Service under Workmen's Compensation Law	Nabors et al	8-6	Died on Senate Calendar		
HB 103	Re: Hospital Governing Board	Brown et al	Died on House Calendar			
HB 114	Battered Child Bill	Dominick et al	6-29	(Covered by SB 8) Died in Senate Health Comm.		
HB 115	Additional funds for Toxicologists	Turnham et al	Died in House State Administration Comm.			
HB 122	L. P. N. License Bill	Fite	Died on House Calendar			
HB 132	Water Pollution Bill	McCorquodale et al	7-13	with amend. 8-17	8-26	No. 574
HB 159	Appropriation for Commission on Aging	Pierce	6-25	7-22	8-10	No. 225
HB 164	County Health Service Salaries	Goodwyn et al	Died in House State Administration Comm.			
HB 198	Water Pollution (Substitute for HB 132)	Thomas	Died in House Conservation Committee			
HB 205	Amend Optometry Law to forbid Chain Store Practice	Turner	6-25	7-22	8- 4	No. 218
HB 240	Abolish Certain Hospital Boards	Young	Died in House Health Committee			
HB 275	Photocopy Medical Records	Etheredge	5-28	Died on Senate Calendar		
HB 283	Exempt Sanatoria From Sales Use Taxes	Vacca et al	Died in House Ways & Means Committee			
HB 289	Restrict Sale of Barbiturates	Teel and Stembridge	7-14	Died in Senate Judiciary Comm.		
HB 294	Restrict Sale of Amphetamines and other Drugs	Teel and Stembridge	7-14	Died on Senate Calendar		
HB 303	Regulating Sale of Barbiturates	Rogers and McDermott	(Covered by HB 289) Killed in House Judiciary Committee			

HB 304	Restrict Sale of Narcotics and Poisons	Rogers and McDermott	(Covered by HB 289) Killed in House Judiciary Committee			
HB 313	Maximum Salary of State Employees	Goodwyn et al	Died on House Calendar			
HB 371	Make Seat Safety Belts Compulsory	Drake	Died in House Transportation Committee			
HB 390	Appropriation Bill	Fite	7-27	8-26	9- 1	No. 770
HB 391	Return Scholarship Loans to Special Educational Trust Fund	Fite	7-27	8-26	9- 1	No. 752
HB 396	Appropriation for Commission on Mental Illness of SRAB	Fite	7-27	8-26	9- 1	No. 775
HB 407	Establish Water Improvement Commission Board	Engel and Hannah	Killed in House Conservation Committee			
HB 619	Two-Year Nurse Education Bill (Companion to SB 119)	Hawkins and Collins	8- 3	Died on Senate Calendar		
HB 627	Re: Persons Under Influence of Liquor or Drugs	Brown et al	Died in House Judiciary Committee			
HB 696	Registration of Sanitarians	Cates	8- 6	8-26	9- 2	No. 800
HB 699	Create New Department of Mental Health	Camp and Bevill	8- 3	with amend. 8-26	9- 3	No. 881
HB 701	Amend Healing Arts Qualifications	Camp	8-17	Died on Senate Calendar		
HB 816	Forbid Water Pollution by Boats	Vacca	8-17	Defeated in Senate—vote 15-18		
HB 829	Establish Meat Inspection Laboratory	Fite	Died in House Ways & Means Committee			
HB 836	Re: Salaries payable to Certain State Officers and Employees in State Service	Nettles	with amend. 7- 1	with amend. 8-17	9- 1	No. 661
HB 874	Cigarette Tax for Health Dept.	Slate and Moore	7-23	with amend. 8-26	with amend. 8-30	No. 654
HB 954	Re: Treatment of Tubercular Patients	Callahan et al	Died on House Calendar			

(Continued on Page 634)

HOUSE BILLS—REGULAR SESSION—(Continued)

NO.	SUBJECT	SPONSOR	PASSED BY HOUSE	PASSED BY SENATE	GOV. SIGNED	NO. OF ACT
HB 955	Control Amphetamine Possession and Sale	Campbell et al	Died in House Health Committee			
HB 1040	Create Board of Health Advisory Council	Turner	Died on House Calendar			
HB 1048	Require Physical Examination of School Children	Locke	Died in House Judiciary Committee			
HB 1075	Eliminate Permanent Attachment of Prenuptial Certificate to License	Ca'es	8-17	8-26	9- 2	No. 803
HB 1077	Re: Liability for Inmates of Mental Institutions	Camp et al	7-30	Died on Senate Calendar		
HB 1081	Control of Drugs which Produce Hallucinations	Locke et al	8- 3	Died on Senate Calendar		
HB 1097	Create Board of Nursing; Regulate Nursing Schools and License (Same as HB 4)	Thomas and Bailes	Died in House Ways & Means Comm.			
HB 1128	Restrict Sale of Narcotics	Collins	Died on House Calendar			
HB 1134	Establish Right of State Board of Health to Approve Water Sources	Turner	8- 3	8-26	9- 2	No. 805
HB 1148	Mental Retardation Program	Engel and McDermott	Died on House Calendar			
HB 1167	Nurse Practice Act (Same as HB 4 and HB 1097)	Thomas	Died on House Calendar			
HB 1249	Privileged Communication of Medical Records	Hannah and Boston	8-13	8-19	9- 1	No. 728
HB 1250	Permits Counties to Set Up Own Health Departments	Hannah and Boston	Died in House Health Committee			
HB 1251	Lauderdale Photocopy Bill	Boston and Hannah	8-13	Died in Senate		
HB 1256	Re: Establishment of an Arthropod Control Board	Rogers et al	8-13	8-19	Exe. Amend. 9- 2	No. 822
HB 1266	Fluoridation of Water	Locke et al	8-13	with amend. 8-26	9- 2	No. 821

SENATE BILLS—REGULAR SESSION

NO.	SUBJECT	SPONSOR	PASSED BY SENATE	PASSED BY HOUSE	GOV. SIGNED	NO. OF ACT
SB 8	Battered Child Bill	Carter	6-22	8-19	8-26	No. 536
SB 9	P. K. U. Testing	Carter	6-15	8-26	9- 5	No. 885
SB 25	Water Pollution Control	McDow and Brannan	Died in Senate Health Committee			
SB 48	Permit Abandonment of Cemeteries for Highway Purposes	Metcalf	6- 4	7-13	with amend. 7-23	No. 155
SB 64	Amend Basic Science Law to Conform with SB 66	Clark	6- 4	8-19	9- 1	No. 669
SB 65	Amend Healing Arts Law to Conform with SB 66	Clark	6- 4	8-19	9- 1	No. 670
SB 66	Foreign Doctors' permit to practice at Medical College	Clark	6- 4	8-19	9- 1	No. 671
SB 78	Licensure of Fhysical Therapists	Givhan	Died in Senate Health Committee			
SB 119	Remove 36-month RN Training Requiremen'	Clark	8-10	8-19	8-26	No. 640
SB 121	Protection of Public Against Rabies	Lolley et al	8-10	8-19	8-26	No. 656
SB 122	Substitute for Battered Child Bill	Carter	Died in Senate Health Committee			
SB 124	Establish New Water Improvement Commission	Clark	Died in Senate Health Committee			
SB 166	Amend Medical Scholarship Bill	Mathews	Died on Senate Calendar			
SB 167	Re: Money Collected by Basic Science Board	Mathews	Died in Senate Finance & Taxation Committee			
SB 172	Inspection of Motor Vehicles	Carter	Died on Senate Calendar			
SB 210	Mandatory Nurse Practice Act	Smith	with amend. 8-10	8-19	9- 3	No. 867
SB 235	Authorize Dental Scholarship Loans	McDow et al	Died on Senate Calendar			
SB 236	Approve Dentist "Blue Shield" Plan	McDow and Givhan	Died on Senate Calendar			

(Continued on Page 636)

SENATE BILLS—REGULAR SESSION (Continued)

NO.	SUBJECT	SPONSOR	PASSED BY SENATE	PASSED BY HOUSE	GOV. SIGNED	NO. OF ACT
SB 250	Establish Alabama Food Processing and Marketing Commission	McDow and Givhan	Died in Senate Finance & Taxation Committee			
SB 251	Provide Jury Trial in Lunacy Cases	Shelton	6-11	6-25	7- 7	No. 105
SB 265	Bond Issue for Medical Branch of U. of Alabama in Huntsville	Roberts et al	Died in Finance & Taxation Committee			
SB 285	Hospital Licensure (Masonic Bill)	McCain and McDow	Died in Senate Health Committee			
SB 352	Substitute for Mental Health Bill	Cooper et al	Died on Senate Calendar			
SB 402	Appropriation to Commission on Aging	Mathews	Died in Finance & Taxation Committee			
SB 463	Increases TB per diem to $7.25	Allen	7-29	8-10	8-13	No. 450
SB 507	Provide Advisory Council to State Board of Health (Same as HB 1040)	Cooper and Clark	7-29	8-19	9- 3	No. 870
SB 510	Re: Fees collected by Commission on Education regarding alcoholism	Clark	Died on Senate Calendar			
SB 555	Mental Retardation Facilities (Same as HB 1148)	Metcalf and Clark	Died on Senate Calendar			
SB 561	Early Education of Deaf Children	Tyson	Died on Senate Calendar			
SB 579	Pharmacy Practice Act	Wilson	Died in Senate Health Committee			

HOUSE BILLS—SECOND EXTRAORDINARY SESSION

NO.	SUBJECT	SPONSOR	PASSED BY HOUSE	PASSED BY SENATE	GOV. SIGNED	NO. OF ACT
HB 18	Subdivision Sewer-Water Bill	McCorquodale	Died in House Health Committee			
HB 21	Health Insurance for Teachers	Cantrell et al	Died in House Ways & Means Committee			
HB 48	Give Preference in State Employment to Handicapped	Blanton	9-15	9-23	9-30	No. 119

HB 81	Forbid Water Pollution by Boats	Vacca	9-14	Died in Senate Seaports Comm.		
HB 85	Hospital Medical Records Photocopy Bill	Etheredge	9-15	9-21	9-30	No. 77
HB 92	Require Control of Lysergic Acid Sale	Locke et al	9-14	Died in Senate Public Health Committee		
HB 93	Amend Law on Physical Examination of School Children	Locke et al	9-14	Died in Senate Public Health Committee		
HB 105	Agriculture Products—Laboratory Bill	Turnham	9-15	9-22	10- 1	No. 132
HB 107	Regulate, Control Water Supplies	Pennington et al	Died in House Ways & Means Committee			
HB 109	Liquor tax for Public Welfare	Pennington et al	9-15	Died in Senate Finance & Taxation Committee		
HB 115	Tobacco Tax—Discount Bill	Fite	Died on House Calendar			
HB 121	Amend Law on Licensing Hospitals, Sanitoria, etc.	Engel	Died in House Ways & Means Committee			
HB 127	Authorize Board of Health to Build Mental Retardation Centers	Engel	Died in House Ways & Means Committee			
HB 196	Bond Issue—Beer Tax for Mental Health	Branyon et al	Died in House Ways & Means Committee			
HB 200	Authorize Board of Health to Build Mental Retardation Centers (Substitute for HB 127)	Engel et al	Died in House Ways & Means Committee			
HB 221	Cystic Fibrosis Research Tax Exemption	Scurlock et al	9-21	9-23	9-30	No. 123

SENATE BILLS—SECOND EXTRAORDINARY SESSION

NO.	SUBJECT	SPONSOR	PASSED BY SENATE	PASSED BY HOUSE	GOV. SIGNED	NO. OF ACT
SB 38	Control of Lysergic Acid—Hallucination Bill (Same as HB 92)	Robison (Pickens)	Died in Senate Public Health Committee			
SB 39	Amend Law on Physical Examination of Children (Same as HB 93)	Robison (Pickens)	Died in Senate Education Committee			
SB 44	Amend Law on Licensing Hospitals, Sanitoria, etc. (Same as HB 121)	McDow	Died in Senate Public Health Committee			
SB 51	Amend Mental Health Law	Cooper et al	9-21	Died on House Calendar		

(Continued on Page 638)

SENATE BILLS—SECOND EXTRAORDINARY SESSION—(Continued)

NO.	SUBJECT	SPONSOR	PASSED BY SENATE	PASSED BY HOUSE	GOV. SIGNED	NO. OF ACT
SB 67	Subdivision Sewer-Water Bill (Same as HB 18)	Clark	Died on Senate Calendar			
SB 97	Authorize Board of Health to Build Mental Retardation Cts. (Same as HB 127 and HB 200)	Cooper et al	9-23	Died in House Health Committee		

HOUSE BILLS—THIRD EXTRAORDINARY SESSION

NO.	SUBJECT	SPONSOR	PASSED BY HOUSE	PASSED BY SENATE	GOV. SIGNED	NO. OF ACT
HB 5	Mental Health Merit System Bill	Thomas and Callahan	10- 8	10-22	10-29	No. 9
HB 33	Vehicle Safety Law	Vacca and Turnham	Died in House Transportation Committee			
HB 34	Lysergic Acid Control Bill	Locke	10- 8	Died on Senate Calendar		
HB 35	Amend Law on Physical Examination of School Children	Locke et al	10- 8	10-22	11- 1	No. 53
HB 54	Mental Retardation Facilities Bill	Engel et al	10- 8	Died in Senate Fin. & Taxation		
HB 59	Higher Education Student Loans	Goodwyn	Died in House Ways & Means Committee			
HB 69	Recognize National Chiropractic Board Certificate	Brown	10-15	Not transmitted to Senate		
HB 75	Good Samaritan (Physicians and Rescue Squads)	Meade	10- 8	Died in Senate Rules Comm.		
HB 91	Inquisition Hearings in Lunacy Cases	Ingram and Teel		Defeated in House		
HB 110	Authorize Chiropractic Examiners to get three-fourths of License Fee	Camp and Turner	10-19	10-22	10-29	No. 39
HB 112	Pharmacy Practice Act	Thomas et al	Died on House Calendar			
HB 122	Amend Mental Health Law	Locke	Died in House Judiciary Committee			
HB 123	Jury trial for mental cases	Locke	Died in House Judiciary Committee			
HB 124	Regarding Records, Mental Health Cases	Locke	Died in House Judiciary Committee			
HB 125	Repeal Mental Health Law	Locke	Died in House Judiciary Committee			

An antibiotic of choice is one that works

TAO works

Susceptibility Results
Staphylococci [2,3,1]

# OF CULTURES	YEAR	% EFFECTIVE
6,725	1962	88.6%
5,440	1963	88.0%
10,384	1964	88.5%

β-Hemolytic Streptococci [2,3,1]

2,448	1962	89.5%
1,519	1963	95.2%
2,492	1964	96.7%

The Product

In a world study of antibiotics *in vitro*[1], TAO had an overall effectiveness of 87.3%, higher than chloramphenicol and erythromycin, and significantly higher than tetracycline and penicillin.

The Plus... Consistent Performance

Yet antibiotics must not only work. They must work consistently. Here are the results from the largest study of microbial susceptibility ever undertaken. In 29,048 cultures of overt staphylococcal and β-hemolytic streptococcal infections, note the consistency of results with TAO.

TAO®
[triacetyloleandomycin]

J. B. Roerig and Company, New York, New York 10017
Division, Chas. Pfizer & Co., Inc., Science for the World's Well-Being™

TAO Rx information

Indications: The bacterial spectrum includes: streptococci, staphylocci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **Contraindications and Precautions:** TAO (triacetyloleandomycin) is not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents, of course, should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. It is contraindicated in pre-existing liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. **References.** 1. Isenberg, Henry D.: Health Laboratory Science **2**:163-173 (July) 1965. 2. Fowler, J. Ralph et al: Clinical Medicine **70**:547 (Mar.) 1963. 3. Isenberg, Henry D.: Health Laboratory Science **1**:185-256 (July-Aug.) 1964.

When uncontrolled diarrhea brings a call for help

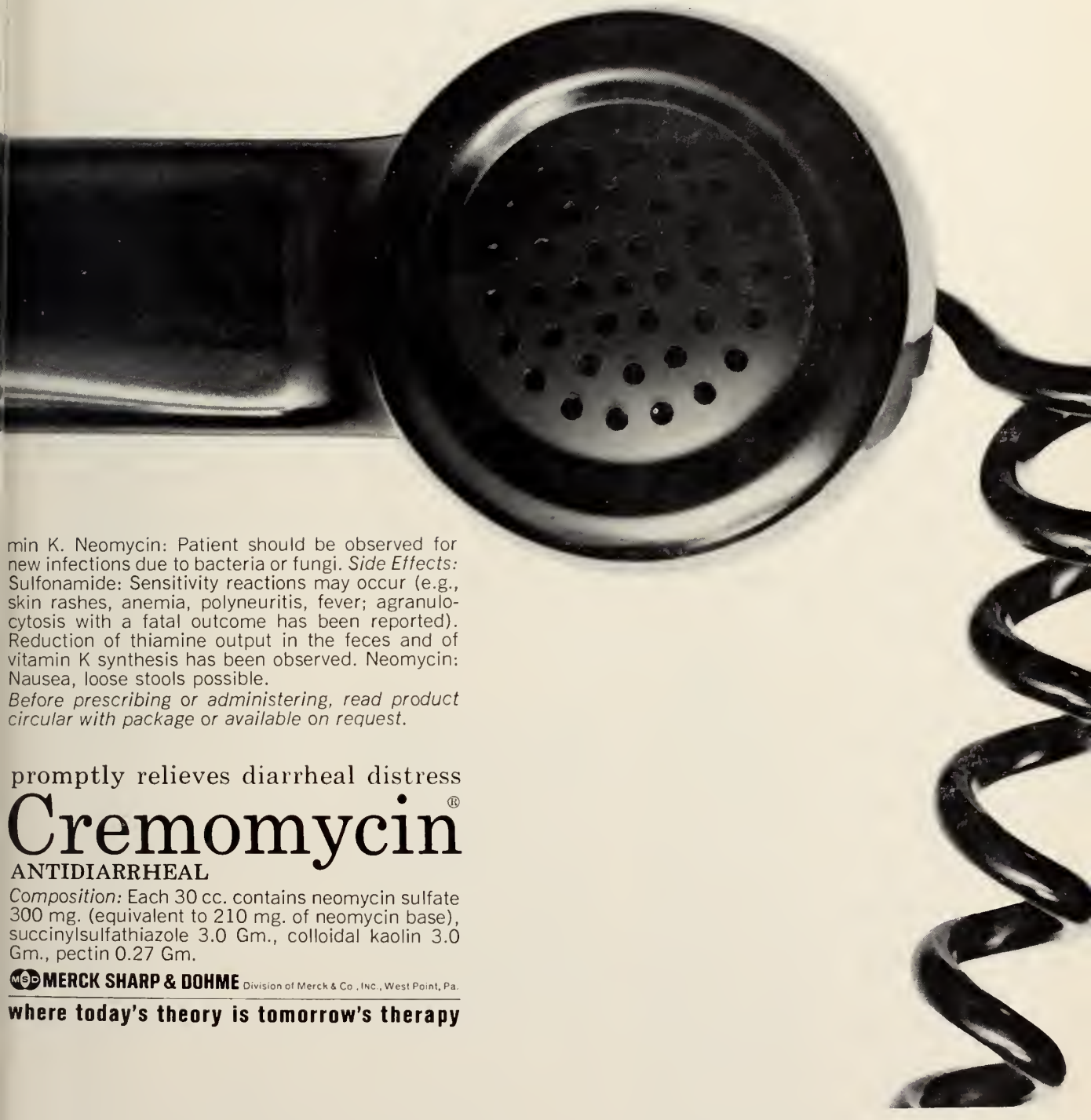


When the diarrhea sufferer has run the gamut of home remedies without success, pleasant-tasting CREMOMYCIN can answer the call for help. It can be counted on to consolidate fluid stools, soothe intestinal inflammation, inhibit enteric pathogens, and detoxify putrefactive materials—usually within a few hours.

CREMOMYCIN combines the bacteriostatic agents, succinylsulfathiazole and neomycin, with the adsorbent and protective demulcents, kaolin and pectin, for comprehensive control of diarrhea.

Indications: Diarrhea. *Contraindications:* Kaolin: Withhold if diverticulosis is present or suspected. *Precautions:* Sulfonamide: Continued use requires supplementary administration of thiamine and vita-

your ℞ for Cremomycin can provide relief



min K. Neomycin: Patient should be observed for new infections due to bacteria or fungi. *Side Effects:* Sulfonamide: Sensitivity reactions may occur (e.g., skin rashes, anemia, polyneuritis, fever; agranulocytosis with a fatal outcome has been reported). Reduction of thiamine output in the feces and of vitamin K synthesis has been observed. Neomycin: Nausea, loose stools possible.
Before prescribing or administering, read product circular with package or available on request.

promptly relieves diarrheal distress

Cremomycin®

ANTIDIARRHEAL

Composition: Each 30 cc. contains neomycin sulfate 300 mg. (equivalent to 210 mg. of neomycin base), succinylsulfathiazole 3.0 Gm., colloidal kaolin 3.0 Gm., pectin 0.27 Gm.

MSD **MERCK SHARP & DOHME** Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

to help relieve pain
in common
anorectal disorders

"non-caine"
Diothane®

Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form... both are now available.

DIOTHANE OINTMENT

COMPOSITION:
diperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:
Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.





DIOTHANE SUPPOSITORIES

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

Merrell

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215/Weston, Ontario

Alabama Department of Public Health

"ICE BALLS" CONSTITUTE HEALTH HAZARD

Division of Health Education and Information

Discovery of germ-laden coolers in Arkansas set off a pre-holiday flurry across the nation which resulted in the banning of sales of the brightly colored, imported plastic drink coolers in six cities and three states.

"Ice Balls", the term most commonly used to identify these products, consist of varicolored plastic balls, cubes, or units in the form of elephants which are designed to be frozen and then placed in drinks where they will chill, but not dilute.

An announcement by Arkansas State Health Officer Dr. J. T. Herron that an analysis of these "Ice Balls" had shown the water within the plastic to be contaminated by bacteria and fungi capable of causing disease resulted in investigations in nearly a score of states. Almost simultaneously, the Wisconsin State Health Department published a report that they also had found staphylococcus aureus and pseudomonas species in their analyses.

Conclusion of other investigations resulted in the curbing of sales in Milwaukee, Cleveland, St. Louis, Chicago, and Baton Rouge. Massachusetts, Rhode Island, and Baltimore also moved to halt sales. In Maryland, two counties asked merchants, early in December, to stop selling these items after the State Department of Health found water in them to be contaminated.

The United States Public Health Service announced December 13 that bacteria which could be harmful had been found in water from plastic novelties imported from Hong Kong. The statement went further to explain that such potentially harmful bacteria would have to be present in the right quantity and under the right conditions to cause disease in humans. As a result of investigations from this source and the Food and Drug Administration they had arrived at no conclusions sufficient to warrent the withdrawal of the product from the market. They were satisfied to let such action remain a local or state prerogative.

In support of their statement a spokesman for the Communicable Disease Center, United States Public Health Service, Atlanta, reported that extensive investigations had failed to trace any illness to the novelty sets. "Germs causing intestinal ailments have been found in the balls, but we are not alarmed about them."

(Continued on Page 645)

WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: **ACTIONS AND USES:** A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental Iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

in iron deficiency anemia for rapid and predictable replacement of iron reserves

imferon®

(iron dextran injection)



LAKESIDE LABORATORIES, INC. • Milwaukee, Wisconsin 53201

(Continued from Page 643)

A state-wide survey was concluded December 30 by the Alabama Department of Public Health, Bureau of Laboratories, under the direction of Mrs. Mary B. Johnson, Chief, Division of Bacteriology, Virology, Fluorescent Microscopy and Parasitology. The results of this study were as follows:

Plastic ice balls, ice cubes and plastic pink elephants for drinks were examined from three sources: Hong Kong, Japan, New Jersey, U. S. A. No. 8800. Bacterial counts ranged from 3,000 to 3,000,000. Bacterial culture showed Herellea, Pseudomonas species, Staphylococcus aureus, Bacillus species, diphtheroidal catalase positive bacilli and fungi. Salmonella and shigella organisms were not isolated from these products.

The "Ice Ball" episode had begun to smolder until a message was issued January 5 by the United States Public Health Service to all state departments of public health. The communique constituted an official warning urging the public to avoid the use of "small plastic water-filled cubes, balls or units in the form of elephants which are used for cooling drinks and are made in Hong Kong." Although no evidence of contamination has been unearthed in these or similar products manufactured in the United States, studies are continuing on such devices made here and in other countries.

Further laboratory examinations by the United States Public Health Service and by its laboratories at the Communicable Disease Center in Atlanta and the Sanitary Engineering Center in Cincinnati have confirmed the presence of human pathogens and a wide variety of contaminating organisms in enough cases for the product to present a potential health hazard. Although no cases of actual illness have been reported as a result of use of these imported ice balls, contamination has been conclusively shown and a potential for sickness is clearly present.

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

Current Morbidity Statistics

1965

	Nov.	Dec.	*E. E. Dec.
Tuberculosis	107	75	113
Syphilis	165	138	100
Gonorrhea	364	344	244
Chancroid	2	1	2
Typhoid fever	1	0	2
Undulant fever	0	0	0
Amebic dysentery	0	1	2
Scarlet fever & strep. throat	374	370	90
Diphtheria	9	4	5
Whooping cough	3	0	10
Meningitis	6	5	10
Tularemia	0	0	0
Tetanus	1	1	1
Poliomyelitis	0	0	2
Encephalitis	0	0	0
Smallpox	0	0	0
Measles	6	10	77
Chickenpox	15	36	88
Mumps	13	18	21
Infectious hepatitis	26	25	25
Typhus fever	0	0	0
Malaria	0	0	0
Cancer	763	459	444
Pellagra	0	0	0
Rheumatic fever	9	17	12
Rheumatic heart	19	24	20
Influenza	330	256	111
Pneumonia	216	420	219
Rabies—Human cases	0	0	0
Pos. animal heads	0	0	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

DECEMBER, 1965

Examination for intestinal parasites	1,098
Typhoid cultures (Blood, feces, urine and other)	292
Examinations for gonococci	1,601
Serologic tests for syphilis (blood and spinal fluid)	22,599
Darkfield Examinations	2
Agglutination Tests	7
Examinations for diphtheria bacilli	90
Complement fixation tests	186
Examinations for Negri bodies (smears and animal inoculations)	139
Water examinations	2,053
Milk and dairy products examinations	3,682
Examinations for tubercle bacilli	3,526
Miscellaneous examinations	9,564
Total	44,839



BRING THE TREATMENT TOGETHER
IN A SINGLE PRESCRIPTION

ACHROCIDIN®

Tetracycline HCl-Antihistamine-Analgesic Compound

Each tablet contains:			
ACHROMYCIN® Tetracycline HCl	125 mg	Caffeine	30 mg
Acetophenetidin (Phenacetin)	120 mg	Salicylamide	150 mg
		Chlorothen Citrate	25 mg

Effective in controlling complicating tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects include drowsiness, slight gastric distress, anorexia, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation), photodynamic reaction to sunlight and increased intracranial pressure (in young infants). Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals. Patient should avoid direct exposure to artificial or natural sunlight; and should not drive a car or operate machinery while on drug. Reduce dosage in impaired renal function. Stop drug immediately at the first sign of adverse reaction.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

Lederle

6075 2912



The Month in Washington

From the Washington Office
American Medical Association

The staff of the Senate antitrust subcommittee has been investigating the rise in quinine prices.

The investigation resulted from receipt by members of Congress of complaints from constituents. Many of the complaints reported a sharp rise in the price of quinidine, a quinine derivative prescribed for irregular heart beats.

The Pharmaceutical Manufacturers Association attributed the price rise to a combination of decreased supplies and rising demands.

A spokesman for the association said that it had become increasingly difficult to obtain quinine's raw material, the bark of the Cinchona tree. He said that Indonesia, once the principal supplier, had virtually cut off its exports of the cinchona bark to the Western world.

Other suppliers, he said, include the Congo and some South American countries. He said these sources were seriously limited, but that the shortage was not expected to reach critical proportions.

The PMA spokesman attributed the rising demand to the appearance of new strains of malaria that are resistant to synthetic drugs developed during World War II as quinine substitutes. This has caused demands for natural quinine to rise sharply in such malaria-infested areas as Vietnam.

The Food and Drug Administration has taken the first steps in implementation of the new law designed to halt illegal traffic in depressant and stimulant drugs.

Acting FDA Commissioner Wilton B. Rankin announced proposed regulations and appointed an advisory committee of experts as authorized by the Drug Abuse Control Amendments law enacted last year.

The Advisory Committee on Abuse of Depressant and Stimulant Drugs, which held its first meeting in late December, assisted the FDA in determining the drugs covered under the new, tighter controls effective February 1, 1966. The new law specified amphetamines and barbiturates but also authorized designation of other depressant and stimulant drugs by regulatory orders of the FDA.

At its first meeting, the advisory committee considered several classes of such drugs, including certain tranquilizers, LSD-25 and other hallucinogenic agents.

The FDA regulations listed details of the records which the new law requires to be kept by every person manufacturing, compounding, processing, selling or otherwise distributing the designated drugs. The first required record is an inventory of stocks on hand of such drugs as of Feb. 1. This initial inventory must contain the identity and quantity of all the specified drugs in finished form under the control of the registrant. Records thereafter must accurately list further manufacture, receipt and disposition of the drugs.

The system of record keeping was designed to permit government agents to follow the movement of the drugs—all of which are prescription drugs—from producer to consumer.

The FDA commissioner is authorized to determine that a stimulant or depressant drug has a potential for abuse, and therefore should be covered under the law, if there is evidence of:

—Individuals taking the drug in amounts

sufficient to create a hazard to their health or to the safety of other individuals or the community.

—Significant diversion of the drug from legitimate drug channels.

—Individuals taking the drug on their own initiative rather than on advice of a physician or osteopath licensed by law to administer such drugs.

Most physicians won't be affected directly by the new federal regulations which state:

"The maintaining of small supplies of these drugs for dispensing or administering in the course of professional practice in emergency or special situations will not be considered as regularly engaged in dispensing for a fee.

* * *

A panel of leading businessmen has warned of the dangers of relying too heavily on government for administration of health and retirement plans.

Such government programs should be used to help the sick, disabled and aged, the panel said, "only if voluntary and private means—truly and tested—cannot adequately meet society's needs Heavy reliance on government can discourage the experimentation and innovation needed to solve our health and retirement problems. Such reliance also can narrow the freedom of choice of people who prefer to meet their needs in their own ways.

This statement was a highlight of a 263-page report by the Task Force on Economic Growth and Opportunity, which was an independent group set up under the sponsorship of the U. S. Chamber of Commerce. The report was entitled "Poverty: The Sick, Disabled and Aged."

The report cited medicare as an example, as follows:

"In an attempt to help low income aged people obtain health care at little personal cost, medicare was attached to the tradition-bound Social Security program. As a result, medicare will help millions of Americans who are not needy by any stretch of the imagination.

"It will be financed by the Social Security payroll tax, a highly regressive tax that places heaviest burdens, in relation to income, on low income workers and on low income consumers who pay higher prices to absorb the cost of payroll taxes levied on employers."

* * *

Measles incidence in 1965 was the lowest in recent years, according to the Public Health Service's Communicable Disease Center.

Through the first 49 weeks of the year, 256,443 cases were reported, far below the average of more than 400,000 annual cases since 1960. There were 478,518 cases in the first 49 weeks of 1964.

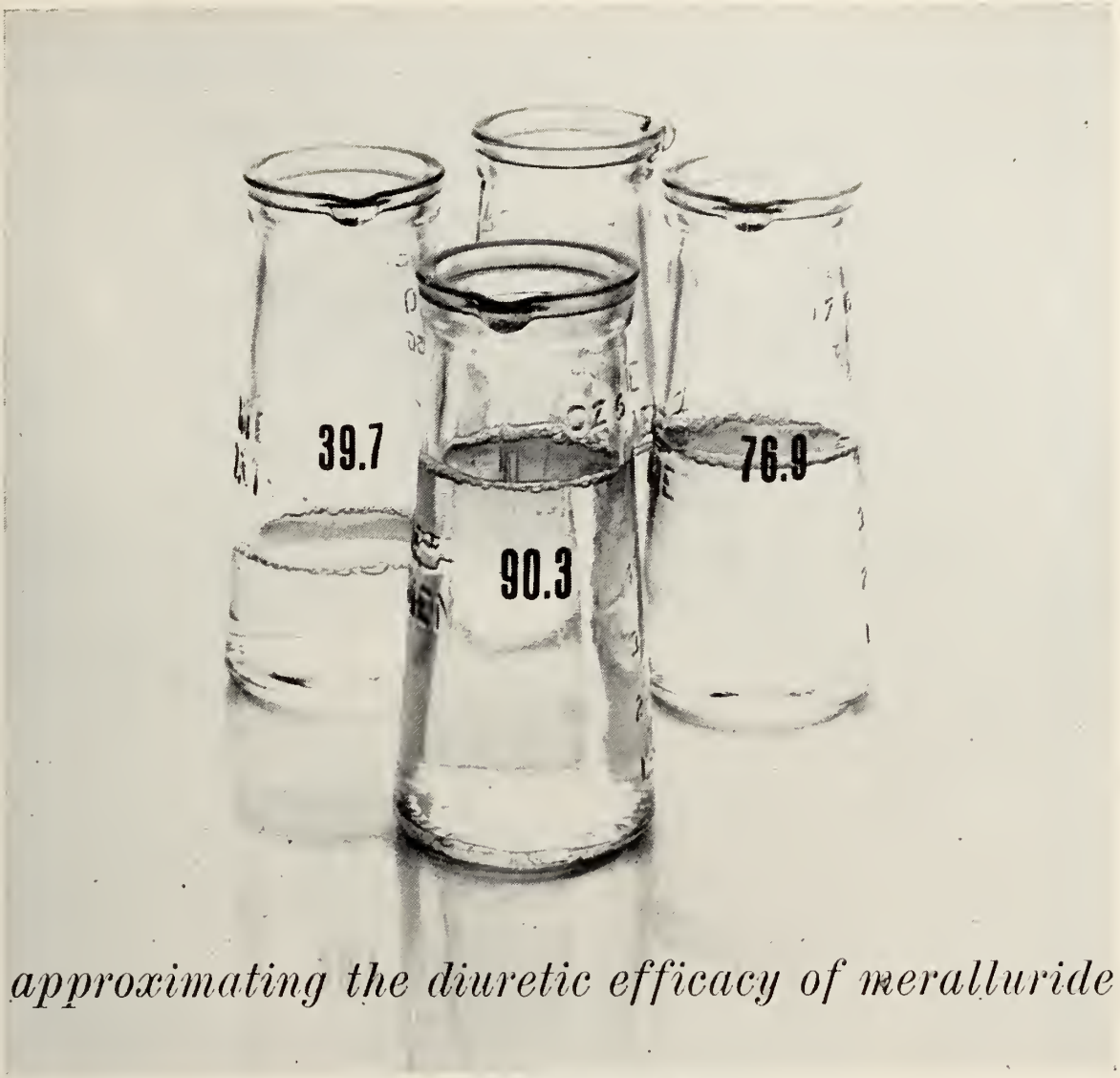
But PHS warned that, if past experience is repeated, major epidemics can be expected in many sections of the country during the first half of 1966.

* * *

The federal government is going to spend more on health and education programs in 1966—but not as much as originally expected principally because of the Viet Nam war.

HEW Secretary John W. Gardner says 1966 would not be a "slowdown year" in his department because of the start of new programs in elementary and secondary education, medicare, water pollution, disease control and other areas.

But, he added, a certain slackening in other programs might be useful. He declined to identify specific projects. He said, however, that they "might be done better if they are started slowly."



approximating the diuretic efficacy of meralluride

METAHYDRIN®

(trichlormethiazide)

To determine the relative efficacy of thiazide diuretics in congestive heart failure, Metahydrin (trichlormethiazide) and three other thiazides were measured against Mercuhydrin® (meralluride injection)—the standard diuretic. "The results leave little doubt that the diuretic efficacy, that is, the 'ceiling effect' in these terms, is not the same for different thiazides."* The assays ranged from about 40% of the effectiveness of Mercuhydrin through 67%, 77% to 90% for Metahydrin. The latter two values were thought to be significantly different from the lowest value and to be therapeutically important.

*Gold, H., *et al*: Closed Panel Conference: Present Status of the Management of Congestive Failure and Advances in Diuretic Therapy, Journal of New Drugs, 1:177, July-August, 1961.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201

IN BRIEF: ADMINISTRATION AND DOSAGE: One 2 mg. or 4 mg. tablet once or twice daily. In acute, severe decompensation, Mercuhydrin® (meralluride injection) may be necessary initially.

PRECAUTIONS: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

SIDE EFFECTS: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have been occasionally noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by administration of thiazides.

CONTRAINDICATIONS: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.

She's on a diet.
She's discouraged.
She needs your help.

You can encourage her with DEXAMYL®
brand of dextroamphetamine sulfate and amobarbital

'Dexamyl' is the mood-lifting anorectic; it not only assures unexcelled control of appetite but also improves outlook.

Formula: Each 'Dexamyl' Spansule® (brand of sustained release capsule) No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming].
Principal cautions and side effects: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Insomnia, excitability and increased motor activity are infrequent and ordinarily mild. *Before prescribing, see SK&F product Prescribing Information. Smith Kline & French Laboratories, Philadelphia* SK&F





FOR A CLEAN START IN VAGINITIS THERAPY

superior cleansing action ■ STOMASEPTINE is "a highly effective mucolytic cleansing agent"[1] that removes debris and flushes out secretions more thoroughly than acid douches.[1] Alkaline STOMASEPTINE "dissolves and removes leukorrheal secretions"[1]—whereas acid douches tend to "coagulate or set the vaginal contents."[2] Low surface tension and release of nascent oxygen contribute to deep penetration and cleansing of rugae.

enhances specific therapy ■ Thorough cleansing of the vaginal vault with STOMASEPTINE enhances the effectiveness of specific vaginitis therapy, ensures maximum contact of topical medication with mucosa.

excellent patient acceptance ■ Anti-pruritic and soothing, pleasantly scented—patients feel "fresh and clean."

1. Weese, H.: Personal Communication, Sept. 25, 1964. 2. Glynn, R.: Obst. & Gynec. 20:369, 1962.

Contains: sodium perborate, sodium bicarbonate, sodium chloride, sodium borate, menthol, thymol, eucalyptol, methyl salicylate and aromatics—6 oz. and 15 oz. jars; cartons of 12 10-gm. packets

Literature and professional supply on request.

STOMASEPTINE®
DOUCHE POWDER

HARCLIFFE LABORATORIES, INC. BROOKLYN, New York 11217

the price of "success"

190
102

Hypertension has been called the price of success... and in some life-situations, the cost of failure. In either event, Metatensin lowers blood pressure, cushions the patient against stress and retards the progress of disease. Metatensin is effective and economical. It is well-tolerated over long periods.

THERAPY
YOU CAN STAY
WITH

METATENSIN®

EACH SCORED TABLET CONTAINS:
Metahydrin® (trichlormethiazide) 2 mg. or 4 mg. Reserpine 0.1 mg.

In Brief: Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery. Contraindications are complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.
Supplied: Metatensin tablets, 2 mg., 4 mg. — bottles of 100 and 1000.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

The discomforts of

DIARRHEA
MUCOUS COLITIS
DIVERTICULITIS
SPASTIC URETERITIS
BLADDER SPASM

. . . are relieved by direct musculotropic action with

Trocinate®

BRAND THIPHENAMIL HCl

Available in 100 milligram pink sugar-coated tablets.

The high therapeutic index permits dosage sufficient to relieve spasm promptly. The usual initial dose is 4 tablets. Maintenance dosage is usually one or two tablets 4 times a day.

Trocinate *BRAND* THIPHENAMIL HCl

BETA-DIETHYLAMINOETHYL DIPHENYLTHIOACETATE HYDROCHLORIDE

. . . directly relaxes smooth muscle spasm
. . . combats hypermotility
. . . non-mydriatic – may be used in glaucoma

Trocinate (Thiphenamil HCl) has been found in three clinical studies, (J. Mo. Med. Assoc., 48:685-6; Med. Rec. & Annals, 43:1104-6; J. Urol., 73:487-93), to be effective and to be free of side-effects. Fifteen years of wide clinical usage has affirmed the safety and effectiveness of Trocinate.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856

now...introducing a **new** high-strength dosage fo

SIGNEM

A 'MAXIMUM SECURITY' ANTIBIOTIC*

* THE BROAD RANGE DEPENDABILITY OF TETRACYCLINE
 long established as the broad-spectrum agent of first choice in a wide variety of infections
* WITH THE ADDED SECURITY OF MEDIUM-SPECTRUM REINFORCEMENT
 triacetyloleandomycin is highly active against the common 'coccal' pathogens, including certain strains of staphylococci resistant to penicillin and tetracycline
* ESPECIALLY VALUABLE IN U.R.I.
 provides decisive therapy in acute respiratory infections and other conditions in which staphylococci, streptococci or mixed flora are frequently encountered
* NOW AVAILABLE IN NEW STRENGTH FOR NEW CONVENIENCE AND ECONOMY
 Signemycin 375—high-potency capsules for simpler administration, greater patient economy

YCIN® 375

(tetracycline 250 mg. triacetyloleandomycin 125 mg.)

Indications: Indicated in the therapy of acute severe infections caused by susceptible organisms and primarily by bacteria more sensitive to the combination than to either component alone. In any infection in which the patient can be expected to respond to a single antibiotic, the combination is not recommended. Signemycin should not be used where a bacteriologically more effective or less toxic agent is available. *Triacetyloleandomycin, a constituent of Signemycin, has been associated with deleterious changes in liver function.* See precautions and adverse reactions.

Contraindications: Contraindicated in individuals who have shown hypersensitivity to any of its components. Not recommended for prophylaxis or in the management of infectious processes which may require more than 10 days of continuous therapy. If clinical judgement dictates therapy for longer periods, serial monitoring of liver function is recommended. Not recommended for subjects who have shown abnormal liver function tests, or hepatotoxic reactions to triacetyloleandomycin.

Precautions and Adverse Reactions: Triacetyloleandomycin, administered to adults in daily oral doses of 1.0 gm. for 10 or more days, may produce hepatic dysfunction and jaundice. Adults requiring 3 gm. of Signemycin initially should have liver function followed carefully and the dosage should be reduced as promptly as possible to the usual recommended range of 1.0 to 2.0 gm. per day. Present clinical experience indicates that the observed changes in liver function are reversible after discontinuation of the drug.

Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacetyloleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.

J. B. ROERIG AND COMPANY
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-being®
New York, N.Y. 10017

MEDICINE AND THE LAW

THE RIGHT OF PLAINTIFF TO CALL DEFENDANT'S EXPERT TO THE STAND

A patient sued two doctors and a hospital to recover for alleged medical malpractice. In rebuttal of the defendant's case, the plaintiff, who had previously rested his case on the testimony of other experts, called to the stand a doctor who had rendered a report to defense counsel as to the propriety of defendant's treatment. Although the defendants did not use this doctor or his report, the plaintiff introduced the report of this doctor in which he found that the defendants had committed malpractice. From a verdict for the plaintiff the defendants appealed. The Appellate Division for the Second Judicial Department unanimously reversed the verdict and granted a new trial.

The Court in finding that plaintiff's use of the doctor and this report was an improper trial tactic stated: "In our judgment, where the expert called is a person who has been employed by the opposing party, and where, in a discovery proceeding prior to the trial, the Court had not made any finding of difficulty in obtaining other expert testimony . . ., there is no warrant for the trial justice to allow one party to subpoena as a witness the other party's expert and to admit into evidence such expert's report to his employer. The practice thrusts the expert into the intolerable position of working for both sides, and into violation of his "ethical obligation not to accept a retainer from the other side. . . ."

"It might also be noted that [the doctor's] opinion was based solely upon his examination of records and writings; his opinion was not formulated upon the basis of his physical

(Continued on Page 659)

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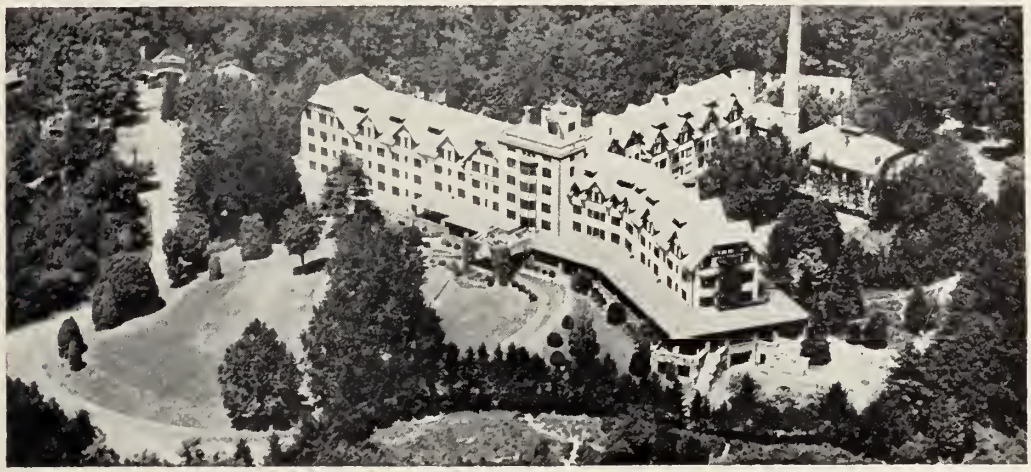
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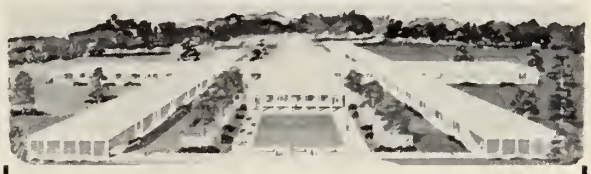
Mark A. Griffin, Sr., M. D.
Mark A. Griffin, Jr., M. D.

MEDICINE AND THE LAW

(Continued from Page 656)

or clinical examination of the plaintiff, so as to make his report available to the plaintiff as part of the conventional exchange of medical information in a negligence action" [*Gugliano* v. *Levi*, App. Div. 2d, 262 N. Y. Supp. 2d 372, 374-375 (2d Dept., 1965)]

Thus it seems apparent that where a medical expert who has not examined the patient renders a report to either side in a malpractice action regarding the propriety of the treatment rendered by the defendant, his report and testimony cannot be used by the adverse counsel unless first introduced by the counsel who retained the expert's services provided that the Court has not already determined that there is difficulty is obtaining other expert testimony.



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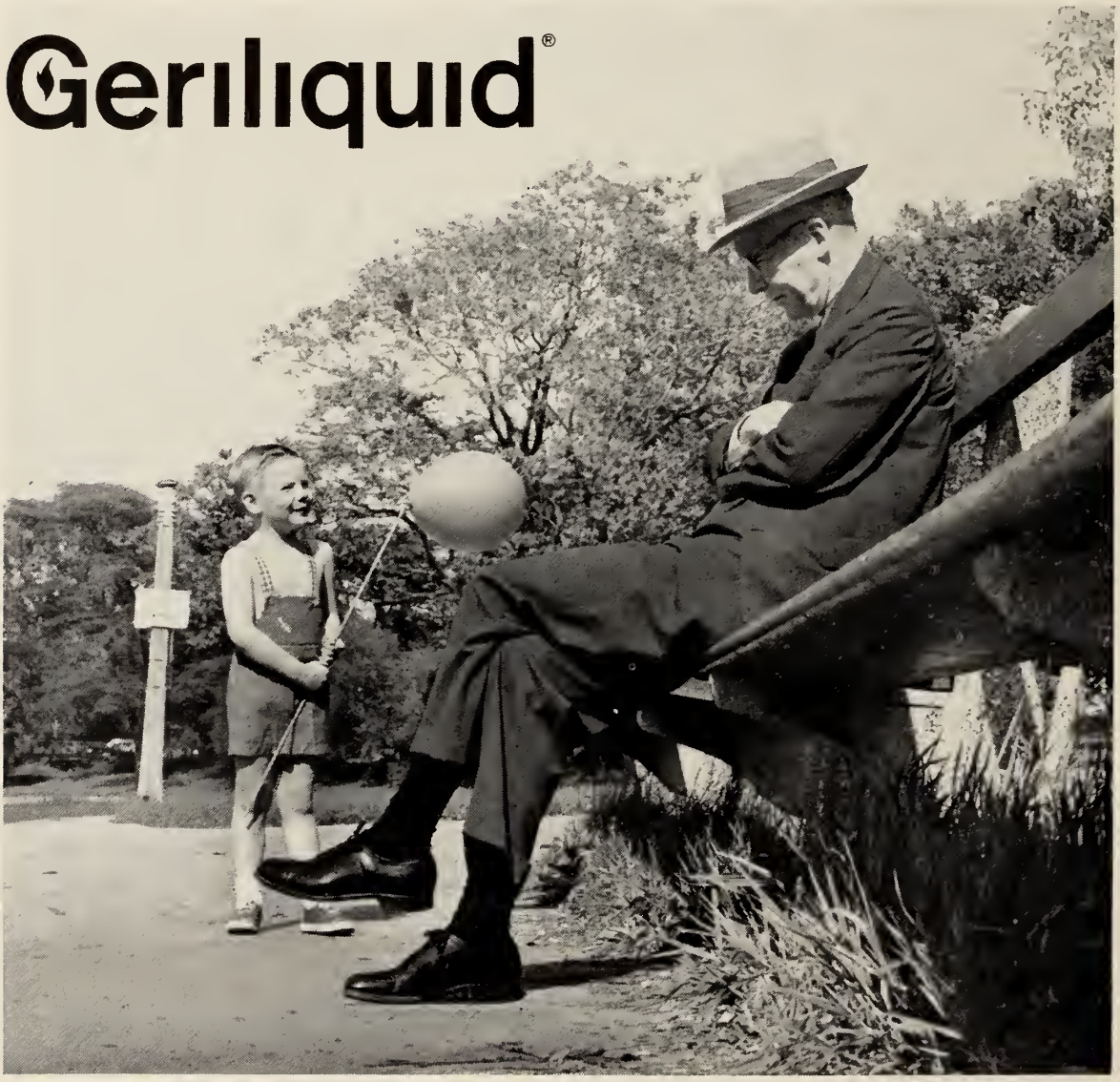
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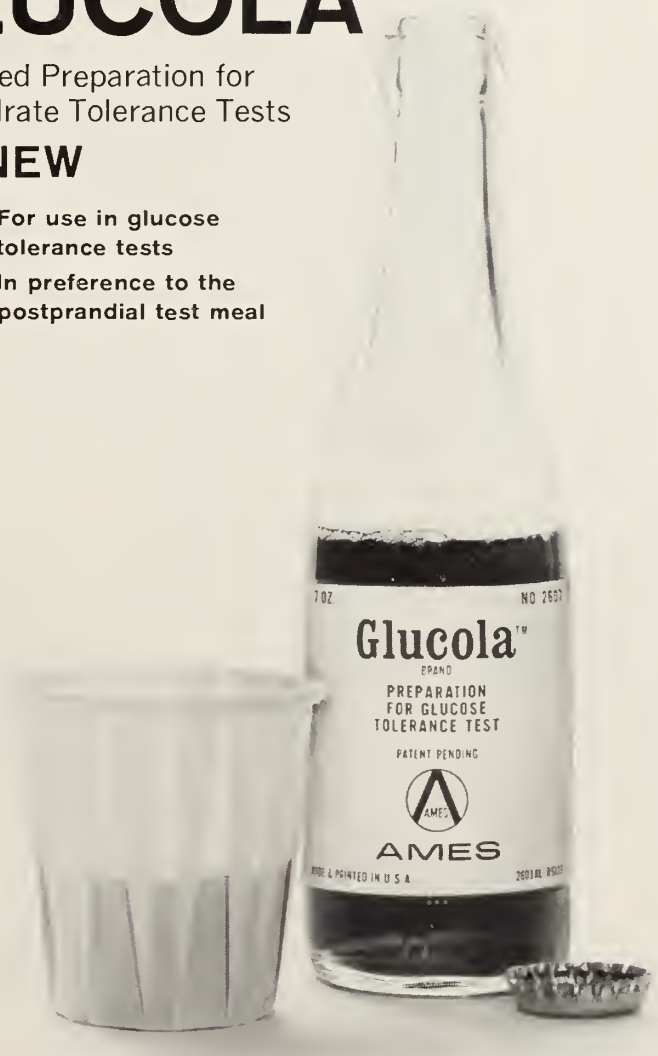
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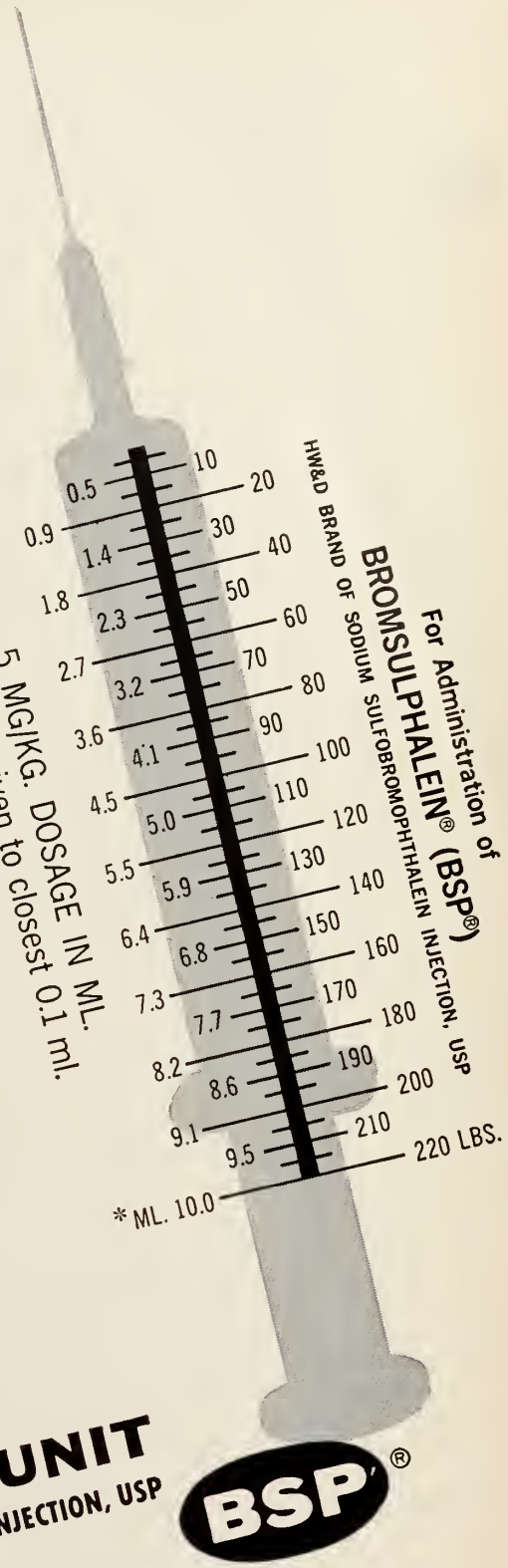
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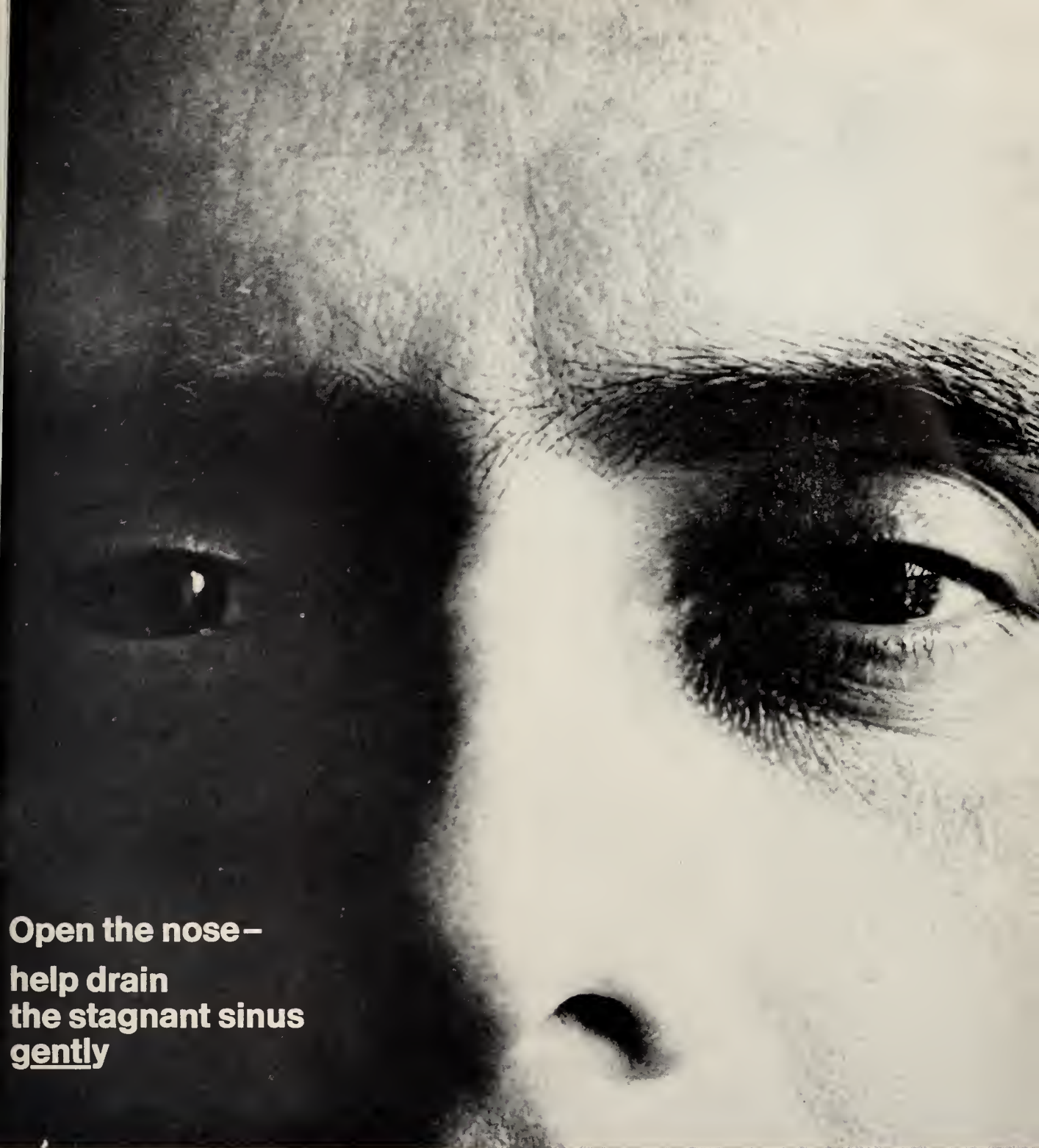
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*Proctor, D. F.: The Nose, Paranasal Sinuses, and Ears in Childhood, Springfield, Ill., Charles C Thomas, 1963, p. 34.

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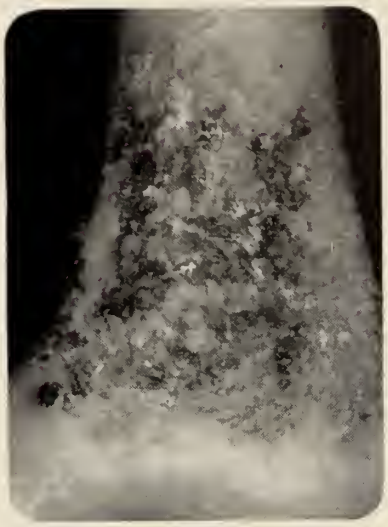
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President's Page



Even more far-reaching than the much-discussed Part A and Part B of Title XVIII is Title XIX of Public Law 89-97. The Title combines the Kerr-Mills law (HOAP and MAA) with (a) Aid and Services to Needy Families with Children, (b) Aid to the Blind, and (c) Aid to the Totally and Permanently Disabled. A single program for medical care of all the needy is thus created, to be administered at State level and financed by Federal grants-in-aid to the States based upon a percentage formula of State-Federal participation.

Since Title XIX is designed to provide medical care for needy people only and is to be administered at State level, it conforms to the principles proclaimed by the AMA for proper use of Federal funds for medical care. For this reason, and because of the primary medical nature of the program, it is particularly important that the medical profession lead in the planning and activation of this program in the various states.

Mr. Carl Mulder, Acting Chief, Division of Medical Service of the Welfare Division of the Department of Health, Education, and Welfare, stated in Philadelphia at the organization of State Medical Society Presidents on November 30, 1965, that "By July, 1975, the law expects that P. L. 89-97 will furnish, throughout the nation, comprehensive care and services to substantially all medically needy individuals. The law permits continued payment of Federal funds to a State only if the Secretary is satisfied that the State is making efforts toward that 1975 goal by broadening the scope of the program and liberalizing its eligibility requirements."

The law requires that the States make proper provision for quality care for these indigent groups and that the State programs must be comprehensive and conform to certain graduated standards during the next few years. For example, for a State Title XIX plan to be considered, its MAA plan by July 1, 1967, must include inpatient and outpatient hospital services; other laboratory and X-ray services; skilled nursing home services; and physicians' services in office, home, hospital, nursing home, or elsewhere.

This means that legislation will be needed in Alabama to expand this program and this will require additional appropriations. Hospital services for Kerr-Mills patients are already being purchased on a realistic per-diem cost basis. Thus far, except for an allowance for three house calls, no professional fees are provided.

Physicians must now adopt the same concept as hospitals, social workers, and others who furnish services to these Federally-subsidized indigents—that of accepting compensation for service on a reasonable and customary fee basis rather than contributing their services entirely as charity or accepting a substandard token fee schedule. It is likely

(Continued on Page 666)

(Continued from Page 665)

that the welfare or health agencies in the State, which are charged with the operation of this program, will use available funds to purchase insurance from carriers for both hospital and physician services for these indigent patients.

Dr. J. O. Finney, President-Elect of MASA; Dr. J. Garber Galbraith, Chairman of the Committee on Aging and the Indigent, and Mr. L. P. Patterson, Assistant Executive Secretary of MASA, attended the National Conference on Federal Medical Assistance Programs sponsored by the AMA in Chicago on January 20-21, 1966. They have made very comprehensive reports with strong recommendations for prompt Medical Association leadership. These recommendations are being considered by the Committee on Legislation, the Board of Trustees, and the Board of Censors.

James G. Donald, M. D.

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The Woman's Auxiliary

MRS. WILLIAM L. SMITH

Guest Columnist

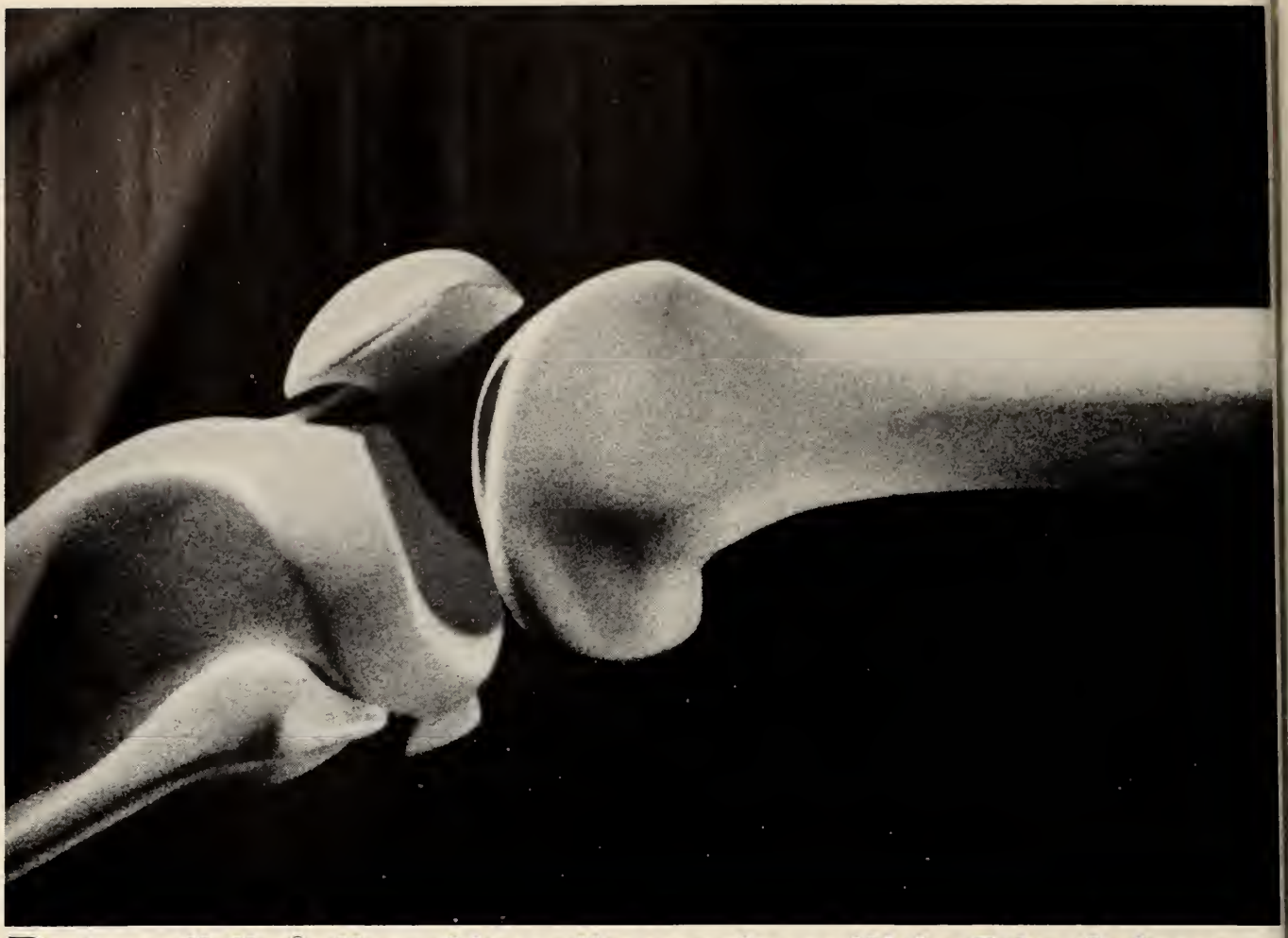
The membership pledge of the Woman's Auxiliary calls for support of the activities of the American Medical Association. As members we can render no better aid to AMA than by helping to strengthen the Medical Association of the State of Alabama. Let us look toward some of the areas in which we may serve.

The January publication of the State Medical Journal was one of the better issues. We are told by the editorial staff that the State Medical Journals Advertising Bureau considers the Alabama Journal as one of the best of its type in the nation. But we are also reminded by the staff that 'doctor reading' is what counts. No matter how good the information, if it does not command some attention from the doctors, it is wasted. The Auxiliary members can perform a real service to the State Association and to their husbands if they will ask that the Journal of the Medical Association of the State of Alabama be brought home from the office and read. Not only is there good scientific material, there are also news, editorial comments, and information from all over the state and nation. Get in the habit of keeping up by reading our State Journal!

Governor George Wallace has designated February as Medical Self-Help Month. Auxiliary members, by attending the classes prescribed in the training course, will not only help themselves but they will support a project endorsed by MASA and executed by our State Department of Health. The general public cannot help but be impressed if the wives of physicians participate in this program.

The 1966 Annual Session will be in Mobile on April 21, 22, 23. Now is the time for Auxiliary members to remind their busy husbands about hotel or motel reservations and any side trips during this time. Dr. James G. Donald, Association President, has arranged an excellent program for the doctors. The Auxiliary meeting will be equally as stimulating. Mobile is always a great city for entertainment and diversified activities such as fishing, golf, sightseeing, boating, and just plain fun. Let us make this year's annual meeting the finest ever.

AMA-ERF, ALAPAC, Health Careers, Doctor's Day, and all other activities of the Auxiliary are important and must not be minimized. But this is another political year. Perhaps one of the greatest services that we can perform would be for all members to be active in local, state, and national politics. It doesn't matter whether we are Democrat, Republican, or Independent. Our earnest participation in the political arena, with the good of the health of all the people and the ideals of organized medicine in mind, is one of our foremost responsibilities. There may be some differences of opinion concerning the candidates and the issues. Just remember, friendship is one thing and politics is quite another.



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Contraindications
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile, or when other potent drugs are given concurrently. Large doses are contraindicated in patients with glaucoma.

Precautions
Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Make regular blood counts. Use greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy.

Adverse Reactions
The most common are nausea, edema and drug rash. Hemodilution may cause moderate fall in red cell count. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently

Dosage
The initial daily dosage in adults is 300-600 mg. daily in divided doses. In most instances, 400 mg. daily is sufficient. When improvement occurs, dosage should be decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

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LET THE WORDS RAIN DOWN

Brevity is now considered the crowning virtue in keeping physicians abreast of the medical times. Praise is heard from afar and near for *The Alabama M. D.*, a weekly newsletter published by the Association, because it contains only abbreviated reports which can be read completely in a few minutes.

Our members like *The M. D.* because they can stuff it into their pockets and scan it at leisure. No article is more than a few hundred words and most are far shorter than that.

Although designed primarily to keep members informed of Association activities, *The M. D.* is being utilized more and more for publication of weightier matters. There is mounting evidence that a paragraph or so printed in *The M. D.* is far more effective than a complete report in detail with valuable interpretations published in *The Journal* or any other publication, including newspapers.

All of this bodes well for the future of *The M. D.* but is it good for organized medicine? Can a few short paragraphs, hurriedly read, provide sufficient information to physicians today, when so many subjects involved are matters of greatest concern?

It has been said that passage of the Medicare law marked a turning point in the practice of medicine and that government involvement in the doctor-patient relationship will become progressively worse. If this be true, the inroads will be made surreptitiously—an amendment here, a regulation there.

To meet these threats it is essential that physicians possess more than a bare outline of the issues. Detailed reporting coupled with careful analysis must become the order of the future, and even this will not be enough. Our membership must somehow find the time to read and understand this information and then decide for themselves when their interests are threatened, and which protective measures must be undertaken.

It is seldom that important issues can be condensed into a few words. Ignorance and misunderstanding of the Medicare law emphasizes this. Intelligent action demands complete understanding, which brings us to two questions:

1. How does the physician budget his time so that he can familiarize himself with important developments relating to his profession?

2. How can he afford **not** to keep himself informed when the future of his practice is at stake?

It is rendering no service to organized medicine when publications condense important subjects to the fewest words possible. Such condensation leads inevitably to oversimplification and omission of facts essential to an intelligent conclusion.

THE PEOPLE SHOULD DECIDE THE ISSUE

Alabama physicians who are experiencing mounting concern over the federal government's usurpation of authority originally reserved to the states by the U. S. Constitution would do well to familiarize themselves with a bill now pending in the Congress (Senate Joint Resolution 103) intended to reverse this trend.

Principal proponent of the measure is Sen. Everett McKinley Dirksen of Illinois, who has borne the cause of conservatism through many a legislative battle. In fact, the bill under discussion is known both as the Constitutional Amendment and the Dirksen Amendment.

In simple language the bill would reverse a 1964 Supreme Court decision that both houses of a state legislature must be apportioned according to population to permit one house to be apportioned along geographic lines.

Here in Alabama both the House of Representatives and the State Senate have undergone sweeping reapportionment by federal court edict and next year voting control with its concomitant benefits will pass from rural to urban legislators.

Without attempting to state whether this shift in power will prove good or bad for Alabama, no one of true conservative inclinations can disagree with Senator Dirksen's efforts to restore this one shred of electoral dignity to the citizen-residents of the state.

There is nothing compulsory about SJR 103. It only provides that geographical factors be taken into consideration in determining the districts from which members of one of its legislative houses will be elected **provided** the voters approve such an apportionment plan as an alternative to a strict population plan for both houses.

The law would place the responsibility strictly upon the consciences of the people—which most of us think is the way our founding fathers intended all government to be operated.

A CEASE FIRE ON THE REGULATORY FRONT?

If the American pharmaceutical industry is to continue to lead the world in productivity and to increase its great investment in the search for ever better, safer drugs . . . the scientific stature of the FDA must be raised. . . . The agency and its incoming management must be given a breathing spell to absorb the vast workload it is charged with handling. The Administration and Congress should work together to arrange this breathing spell—a temporary halt to public investigations of the FDA's stewardship—and no new FDA regulatory programs should be enacted during this period.—Walter A. Munns to Medical Society Executives Association, November 30, 1965.

* * *

DEARTH OF NEW DRUGS IS NO COINCIDENCE

" . . . New drugs are now fewer in number, slower in coming, and more costly than ever to produce. It is no coincidence, in my opinion, that the number of new single chemical entities introduced in the U. S. prescription pharmaceutical market has fallen from a high of 63 in 1959 to 18 in 1963, and finally to 17 in 1964. This year, for the first time since 1959, it appears that there will be an increase in new products. The number of new drugs approved so far this year is 17. You will note that 1959 just happened to mark the beginning of the Kefauver investigation.—C. Joseph Stetler to Southern Medical Association, October 31, 1965.

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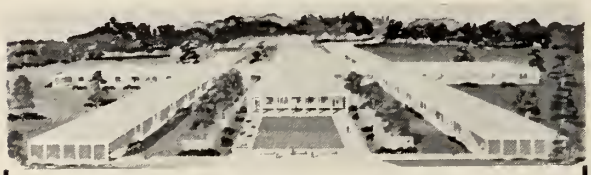
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IF YOUR BABY CRIES LOUDLY AND PERSISTENTLY, you should be somewhat assured that he will be intelligent. Research conducted at Long Island Jewish Hospital, New York, seems to confirm a relationship between a baby's cries and his IQ. Cries of 38 babies between 4 and 10 days old were taped. Three years later a study showed that the normal children with high IQ's had cried with greater force and duration than those who later showed low IQ's. In fact, the latter group had been characterized, as infants, by feeble, "kitten" cries.—*GP*, October, p. 13.

* * *

VANITY IN THE MIDDLE AGED is a good thing, reports Dr. Jose C. Montero of the Stanford University School of Medicine. Some self-admiration can induce people into activity and exercise in attempts to preserve a youthful appearance. And exercise apparently produces changes in the body that "run counter to the trend usually seen with the onset of degenerative diseases." So "it would seem feasible to employ exercise as a preventive measure."—*GP*, October, p. 203.



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meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

Before prescribing, consult package circular.

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even when complicated by anxiety, tension, insomnia, agitation or rumination.

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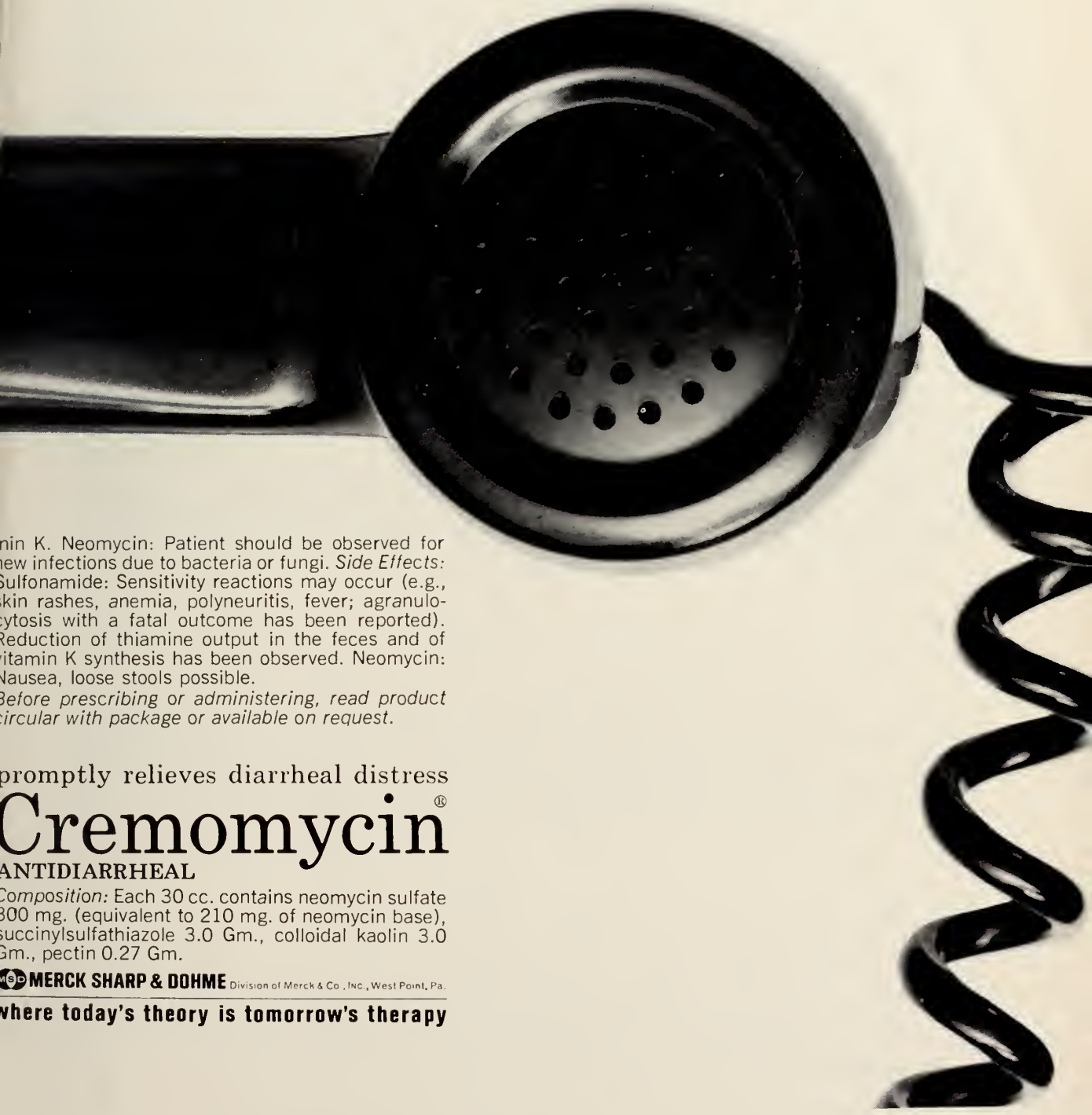


When the diarrhea sufferer has run the gamut of home remedies without success, pleasant-tasting CREMOMYCIN can answer the call for help. It can be counted on to consolidate fluid stools, soothe intestinal inflammation, inhibit enteric pathogens, and detoxify putrefactive materials—usually within a few hours.

CREMOMYCIN combines the bacteriostatic agents, succinylsulfathiazole and neomycin, with the adsorbent and protective demulcents, kaolin and pectin, for comprehensive control of diarrhea.

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your ℞ for Cremomycin can provide relief



nin K. Neomycin: Patient should be observed for new infections due to bacteria or fungi. *Side Effects:* Sulfonamide: Sensitivity reactions may occur (e.g., skin rashes, anemia, polyneuritis, fever; agranulocytosis with a fatal outcome has been reported). Reduction of thiamine output in the feces and of vitamin K synthesis has been observed. Neomycin: Nausea, loose stools possible.
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promptly relieves diarrheal distress

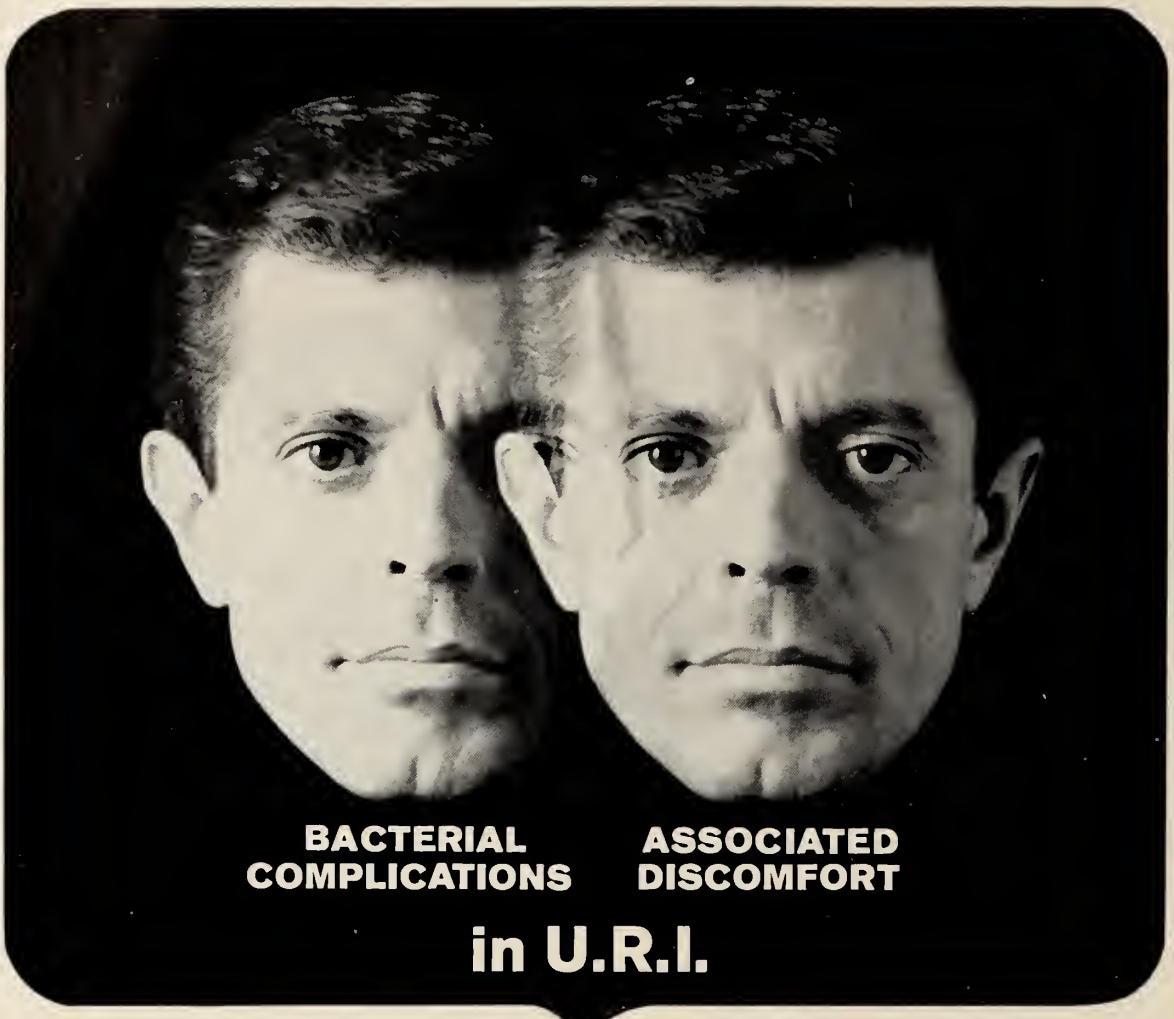
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Composition: Each 30 cc. contains neomycin sulfate 300 mg. (equivalent to 210 mg. of neomycin base), succinylsulfathiazole 3.0 Gm., colloidal kaolin 3.0 Gm., pectin 0.27 Gm.

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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

Contraindication: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

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persistent insomnia

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when emotionally based complaints fit the symptom profile of depression



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Clinical Considerations: **Contraindications**—Glaucoma, urinary retention, bone marrow depression, pregnancy, drug-induced CNS depression. **Precautions**—The same those for the two components, perphenazine and amitriptyline. Use carefully in patients with histories of convulsive disorders or adverse reactions to phenothiazines. ETRAF potentiates effects of antidepressants, CNS depressants, atropine, phosphorous insecticides, and heat. The antiemetic effect of the perphenazine component may conce existence of brain tumor, intestinal obstruction, or toxicity due to overdosage of other drugs. Consider the possibility of potentiation in combined use with MAOI drugs. Ge erally allow two weeks between therapies. Not recommended for use in children. **Warning:** Patients who become drowsy with ETRAFON should be cautioned against driving car or operating machines requiring alert attention. Response to alcohol may be potentiated. **Side Effects**—Similar to those reported following the use of either compone when used alone. For perphenazine alone, side effects caused by any of the phenothiazines may occur. These include extrapyramidal symptoms, autonomic reactio (including hypertension), blood dyscrasias, liver damage, endocrine disturbances, allergic reactions, peripheral and cerebral edema, reversed epinephrine effect, grand m convulsions, polyphagia, reactivation of psychotic processes. For amitriptyline alone, drowsiness, hypotension, numbness and tingling of extremities, transient confusion (high dosages), activation of latent schizophrenia (although perphenazine in ETRAFON may prevent this reaction in some cases). Dose-related anticholinergic reactions are po sible. Rare appearance of agranulocytosis, jaundice, and peripheral neuropathy, all possibly of drug origin, have been reported in patients receiving amitriptyline. For mo complete details, consult Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Union, New Jersey 0708

(1) Lehmann, H. E.: Psychosomatics *6*:266, 1965. (2) Splitter; S. R.: Psychosomatics *6*:322, 1965. (3) Smith e Incas, J.: Internat. J. Neuropsychiat. *1*:220, 1965. (4) Coffee, H. I J. M. A. Georgia *53*:107, 1964. (5) Bowes, H. A.: Psychosomatics *5*:44, 1964. (6) Pennington, V. M.: Combined Psychopharmacological Treatment of Depression, Scientil Exhibit, 18th A.M.A. Clinical Convention, Miami Beach, Nov. 29-Dec. 2, 1964. (7) Dorfman, W.: Psychosomatics *5*:7, 1964. (8) Mattey, W. E.: Current Therap. Res. *5*:310, 196

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More certain broad-spectrum relief: ETRAFON is a broad-spectrum psychotherapeutic agent, capable of symptomatic relief not achieved with either drug alone in mixed emotional disorders. Pennington[6] states: "Since neurotic and psychotic anxiety and depression are simultaneously present in varying degrees, these two types of phrenotropic drugs in combination are more effective than either alone." Dorfman[7] and Coffee[4] report that patients unimproved on amitriptyline alone have responded to the combined therapy.

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Indications: 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

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for the relief of low back sprains and strains

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Guest Editorials....

WHOSE IMAGE?

ROBERT E. WESTLAKE, M. D.

We all know the line about patients respecting their own doctors, but the public (i.e., the same patients) has lost its respect for "doctors." Presumably, the image in trouble is that of organized medicine. But do we, and should we, as individual physicians really place any organization's image above our own? I think not. Therefore although I would like organized medicine, especially ASIM, to be respected by all our publics, general and specific, I am really concerned about individual not collective medical images.

Public relations for medicine is, therefore, personal doctor-patient relationships. We should, I believe, re-examine this relationship, not as public relations image makers, nor ad men, nor public health experts, but as physicians.

Somehow, in the last 25 years, physicians seem to have become confused about their role. For instance, in the patient-doctor relation "who is really in charge?" (Don't answer "the doctor, of course" too quickly.) Our profession, like the unfortunate bankers in the great depression of 30 years ago, has been caught in a social dilemma created by the times. The bankers reacted by hiring the Madison Avenue ad men who have created the current image of "your friendly banker." Physicians, as individuals, have, I believe, been persuaded that they too should woo their client's favor rather than their respect. We must remember that a profession serves needs, not wants. The situation reminds me of parents trying to be "pals" to their children, then wondering why their influence has diminished. Who is in charge, indeed?

I suggest, therefore, that Internists lead the way in reasserting our authority as a necessary corollary to our responsibility.

There is also, I believe, confusion about the individual physician's role in his community. At one time his local citizenship was very special, with equivalent responsibility for community leadership shared by only a few others—the town lawyer, the school teacher and the minister, priest or rabbi. Today here are many educated citizens able to share part of the burden of special citizenship. A physician, unless he has a special interest in community affairs, need not feel any special obligation for any community affairs except those dealing with health.

In those areas of community life dealing with health, the physician, as an individual, must not take a back seat to anyone. We must excel in the organization of medical care at all levels, as well as in medical care itself. We must recognize what we alone can do—and do it.

This means leadership in many aspects of hospital affairs, recently left to administrators; special attention to welfare medical programs, usually left to politicians; and involvement in voluntary health organizations and community health planning, so often left to business leaders.

First and most important, we must care for all of our patients as we have in the past, no matter who the third party may be, even if the third party is our government itself.

Of course we should work to make third-party arrangements ideal for the best of medical care. I suggest the following as ideal

(Continued on Page 682)

Doctor Westlake is President of the American Society of Internal Medicine. Although his views were directed primarily toward members of that organization, the Editors of the Journal of the Medical Association of Alabama believe that all physicians will find his thoughts stimulating and challenging.

(Continued from Page 681)

circumstances under which even government might serve as a third party:

Usual, reasonable and customary fees produce satisfied physicians. They should be approached.

Secondly, comprehensive coverage interferes least with the availability and the decisions of medical care, providing satisfied physicians and patients. Insured medical care should be broad in scope.

And finally, only review by practicing physicians of the quality of care and the use of facilities is effective and acceptable. Professional review committees of physicians are here to stay.

When these conditions are satisfactorily met, the identity of the third party holding the health stakes does not matter.

We can, I believe, take good care of patients under government programs, and ASIM and our component societies will work to create the necessary conditions. Your personal public image as a physician, the only image which really matters, demands it.

Published in The Internist, Sept.-Oct., 1965 and reprinted by Missouri Medicine.

LEGAL OPINION

Hospital Found Liable For Defective Equipment

A surgeon is supplied by a hospital with a defective surgical instrument. As a result, a patient is left scarred.

Was it the doctor's duty to look for defects in the instrument before using it? More important, was the hospital negligent in supplying the defective instrument? These questions have just been considered by the Alabama Supreme Court, reviewing a lower court decision in a negligence case.

The issues arose as Mrs. Laura Camp lay on an operating room table in the South Highlands Infirmary awaiting a skin graft. Her surgeon planned to remove a patch of skin from the front of her right thigh and graft it over an area on the calf of her right leg where she had suffered burns.

Using one of the hospital's dermatomes, the surgeon removed a strip of skin from the donor site, but found the strip was too thick. Resetting the gauge on the machine he removed another patch of skin, but found this one also too thick. He then sutured the two patches of skin back onto his patient's thigh, discontinuing surgery.

Mrs. Camp was left with two permanent scars, and immediately sued the hospital. In her complaint, she charged that she had been greatly injured when deep cuts were made on her body, and that she had suffered great pain, mental anguish, and permanent damage and scarring to her leg. The hospital had been negligent, she said, because it had allowed the defective instrument to be used when it should have known it was defective.

When a jury in Jefferson County Circuit Court awarded Mrs. Camp $10,000 the hospital appealed to the Alabama Supreme Court. Reviewing the evidence, the court declared that the institution should have known about the defect. "The general rule seems to be that equipment furnished by a private hospital for a patient's use should be reasonably fit for the use and purposes intended. When a hospital furnishes defective equipment, and it causes an injury, liability can be imposed as for negligence."

Other evidence indicated, the court pointed out, that surgeons do not normally dismantle instruments before surgery to look for defects. Instead, they customarily accept the instruments provided by the hospital as suitable for use. The state supreme court therefore upheld the lower court judgment in favor of the patient.

(Ala. Supreme Ct., 6th Div., No. 841)

Compiled by Commerce Clearing House for *Medical World News*

THE THIRD PARTY

VINCENT J. TESORIERO, M. D.

President, Medical Society of the County of Kings and the Academy of Medicine of Brooklyn, Inc.

To maintain his status and preserve his freedom, the physician today should be well versed in economics, history, sociology and politics as well as in medicine. These are difficult needs to meet, but perhaps a consideration of the effect of the "third party" in medicine as viewed by the sociologist is pertinent.

Hippocrates said that "medicine consists of three things: the disease, the patient, and the physician. The physician is the servant of the art." The Creed of Maimonides advises the physician to see in the sufferer, the entire man. He commits the doctor to the custody of the sick, to understanding and compassion, to truth and to wisdom. These thoughts are also embodied in the modern "Professional Spirit" as described by Leonard W. Larson, past-president of the A. M. A.

One of the essential qualities of a good clinician is interest in humanity, for the secret of the care of the patient is caring for the patient.

Today the practice of medicine is highly complex. Furthermore, both physicians and patients are involved in changing patterns of relationships, due to changing methods of organizing and financing medical services. Medicine is caught up in the whole current of social, economic and political change affecting our nation and the entire world. The physician must not forget that medicine exists for just one purpose—to serve humanity—and he will strive for excellence in meeting that purpose. No matter how or to what degree the scientific and socio-economic patterns of medical practice may change, we have the responsibility to preserve and invigorate the essence of the professional spirit. Social, economic and psychological factors may alter and aggravate the organic as well as the functional disorders.

It is the irony of progress that the more successful we are in curing and controlling diseases, the more problems we create for society. These are found in the increasing dependence on third parties, urbanization, better transportation, the shift of the site of medical services, the increase in life expectancy, the large number of aged and the increasing general population numbers.

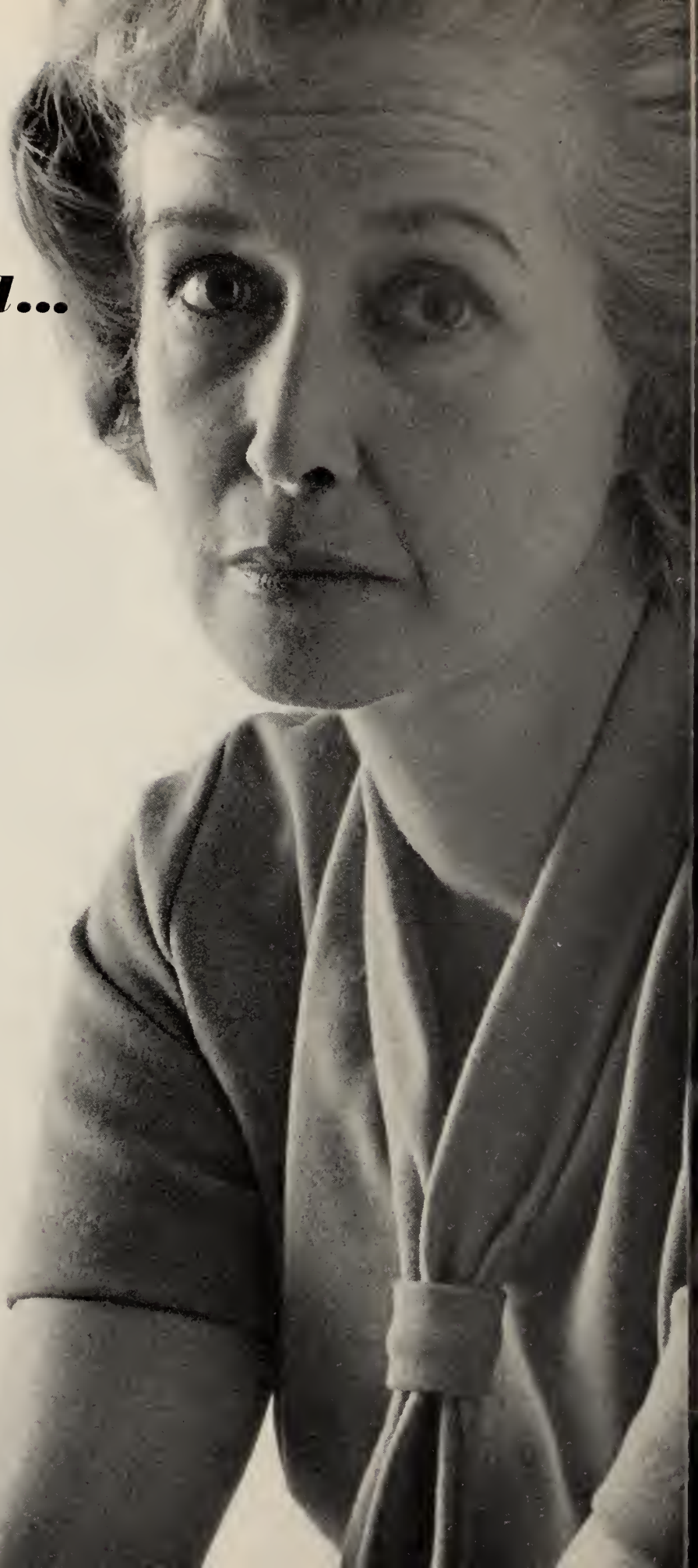
Whenever a third party becomes involved in medical care, it has a vested interest in either the patient or the doctor and, therefore, its decisions are prejudicial and the common good becomes distorted into the good for the specific group. The entrance of the third party between the aged and the physician entails a breach in the traditional relationship. The third party in this case is the "political directorate."

The third party entrance of labor, insurance companies and political parties will weaken the bond between patient and physician. If the relationship is not a voluntary one, it weakens the confidence of the patient and violates the privacy of the patient. A succession of clerks must scrutinize the record; for their agencies are paying the bills. Knowing this the patient may be reluctant to divulge all the factors involved in his illness, thus handicapping the physician.

Bureaucracy forces conformity and fosters mediocrity. Every patient is unique; his response to disease and treatment is typical only to himself. He therefore requires individualized and personalized attention. This ideal situation is present only when the doctor has full freedom in patient care. This leads to better medicine since it fosters an attitude of complete responsibility and pride in his work, benevolence and respect for his patient. The entrance of a third party, interposed as it is between the patient and physician, defeats the basic desires of both. The result is poorer medical care.

Reprinted from The Bulletin, Oct. 1965.

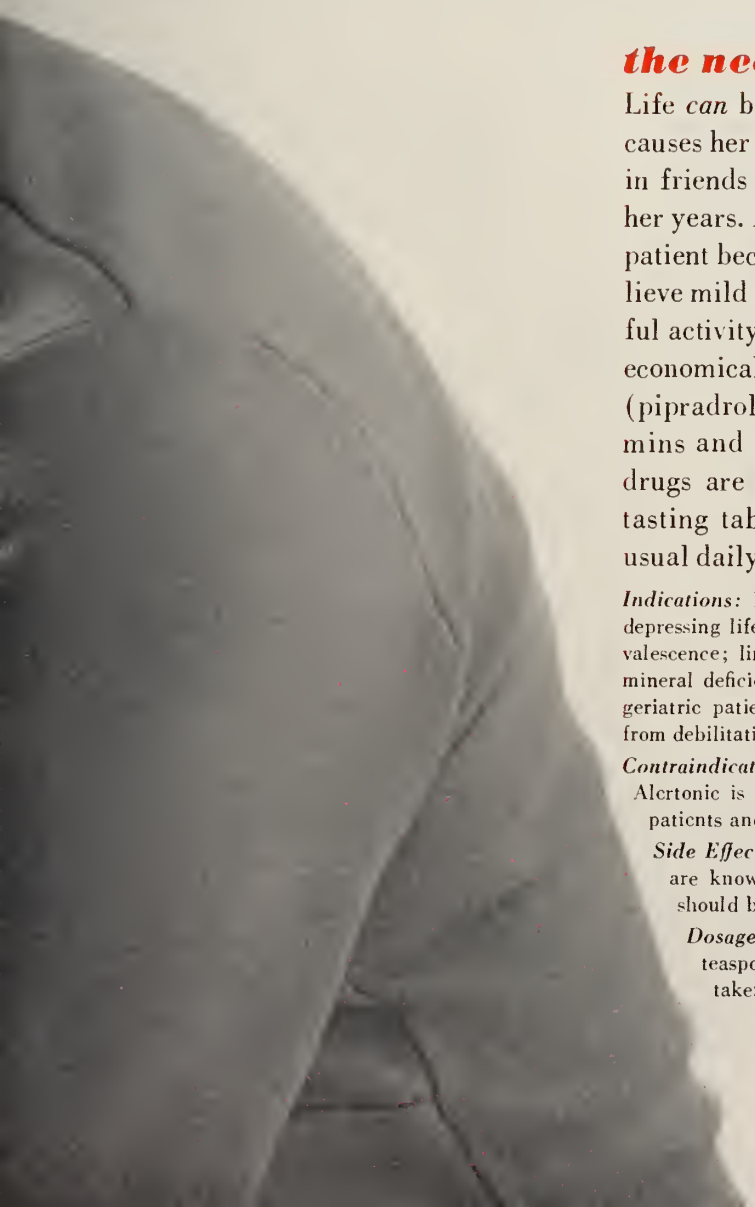
too young
to be so tired...



revive interest...restore activity promptly with Alertonic®

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline†, 100 mg.; inositol†, 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.



the need for a tonic knows no age

Life *can* begin at forty—except when functional fatigue causes her to feel tired all the time; to start losing interest in friends and surroundings; to look and act older than her years. Alertonic—*a prescription tonic*—can help your patient become her normal self again. Alertonic helps relieve mild depression, revive interest and restore purposeful activity promptly...with a formula that is efficient *and* economical. Alertonic contains a mild central stimulant (pipradrol hydrochloride), 15% alcohol, essential vitamins and minerals. No hormones or MAO-inhibiting drugs are included. No iron. No iodine. One pleasant-tasting tablespoonful before each meal comprises the usual daily dose.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS-stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive-compulsive states.

Side Effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

THE WM. S. MERRELL COMPANY
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Merrell

Rise In Public Assistance Under Medicare To Have 'Greatest' Impact on Ethical Drug Industry: Parker

Public assistance payments for drugs and medical supplies under Medicare's Kerr-Mills type programs will have the "greatest immediate effect on the prescription drug industry," according to Dr. Robert P. Parker, General Manager of Lederle Laboratories, a Division of American Cyanamid Company.

Speaking before the Midyear Meeting of the Pharmaceutical Manufacturers Association, in Chicago, Dr. Parker pointed out that vendor payments for drugs and supplies leaped from $45 million in 1959 to $100 million in 1964. Unofficial estimates, he said, project a doubling of such welfare expenditures in the next two or three years.

Under Title 19 of the new law, Dr. Parker indicated "it will be politically impossible for states to abandon existing public assistance programs." Many states rather will be forced to expand their existing Kerr-Mills coverage or to initiate it for the first time. He explained that for states with adequate coverage, the newly provided extended coverage must be adopted to maintain their existing program.

"These provisions," he declared, "seem to be the stimulant to the greatly expanded requirements for drugs and supplies, as well as other services, under the 1965 act."

Turning to the widely discussed question of cost of drugs dispensed under welfare programs, Dr. Parker cited the increased cost of hospital and nursing home care expenditures for which there has been "less publicity."

During the past five-year period, he said that hospital and nursing home care expenditures (rooms, food, laundry, maintenance) have experienced a growth rate **three times** that of drug and supply costs. Drug costs are not strictly "additive" to hospital and nursing costs, Dr. Parker continued, because so frequently drug therapy guards against hospital admittance and shortens hospital stays.

"Accordingly, drug therapy must inevitably control the increase in welfare costs by eliminating substantial hospital and nursing care expenditures which cost," he asserted, "approximately eight times the drugs and which are growing in cost about three times as rapidly."

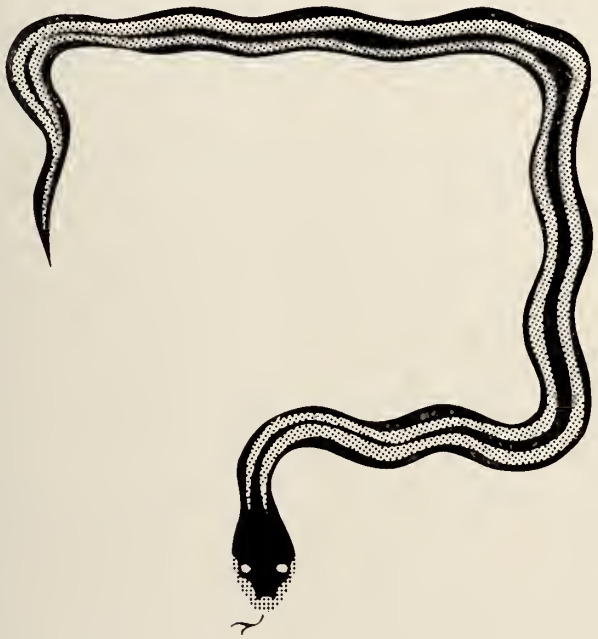
With states being confronted with increasing costs under either new or expanded Kerr-Mills programs, Dr. Parker indicated that one approach is to request or require the prescribing and dispensing of marginally produced, non-branded drugs. In fact, the Lederle executive pointed out, seven states already have—in some manner—stipulated the use of such drugs and several others have made proposals along this line.

Citing the "myths of the non-branded, phantom, drug," Dr. Parker warned the assemblage of ethical drug executives that "it will be most important to be alert to this subject and responsive to the issue." He explained that the federally subsidized programs will be largely administered at local or state levels. "It will therefore be vital," he declared, "that all members of the health team participate in one or another aspect of the programs to ensure their efficient and economic management and performance."

"In this way," Dr. Parker affirmed, "the trend in prescribing and dispensing of non-branded prescription drugs of second-class or dubious quality may not deviate very greatly from the trend that exists today."

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects . . . Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

CHARMS THE HYPERACTIVE COLON



CANTIL®

(mepenzolate bromide)

helps restore normal motility and tone

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide) —25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL —containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1. Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

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Head Start Child Development Programs

Avery Cotton, M. D. and G. H. Holman, M. D.

The Head Start Child Development programs were first conceived by the Office of Economic Opportunity and announced in February 1965. These programs were put into effect July and August 1965 through the Community Action Programs. The primary aim of Head Start was to reach the preschool child and his parents living in poverty and at first was designed for just one such two months crash program. The over-all success of the program, however, demonstrated that this was a much needed and acceptable plan. Therefore through Congressional mandate, the Head Start component of the War on Poverty has become an on-going program and is now being developed with three program categories available to those communities wishing them:

1. Follow-through programs including health, education, social service, and parent activities during the 1965-66 school year for those children who participated in HEAD START this last summer.
2. Full-year programs for preschool children three years of age or older.
3. Short-term programs next summer for children who will enter school in the fall of 1966.

Funds for Head Start programs will be provided through the Community Action Programs of the Office of Economic Opportunity. Up to 90% of the total cost will be thus provided, the local share of the cost, 10%, may be made up either in cash or in kind. Applicants should, in planning their programs, consider use of funds from sources other than the Community Action program of the Office of Economic Opportunity. The Elementary and Secondary Education Act, providing funds for public schools is one major source; another is from the Children's Bureau under the Social Security Amendment of 1965. It is anticipated that communities will spend 20% to 30% of their total anti-poverty allotment on early childhood programs. These may include all three types of Head Start programs enumerated above. Communities wishing such programs for their deprived children may get information from the Regional Office of Economic Opportunity on the total amounts available to them under the Community Action Program and other resources such as Title I mentioned above. Each community will do its own planning and decide how it will use its allotment. Any question regarding this should be directed to your regional office; address your queries to Director, Head Start Program, Office of Economic Opportunity, 101 Marietta Street, Second Floor, Atlanta, Georgia, 30303.

During the summer of 1965 over 500,000 preschool children from economically depressed families were given medical and dental examinations, and enrolled in a two to eight weeks child development and educational program. These programs were highly successful, reaching many more children than was anticipated and identifying considerably more dental and medical problems than had been foreseen.

Thus Head Start is a program designed for the whole child—not just his medical and dental care. The following are the areas that should be developed in each Head Start center:

1. Educational
2. Psychology
3. Social Welfare
4. Nutrition
5. Supervision of Play
6. Medical Care
7. Dental Care

This paper is presented to explain only the medical and dental aspects and to suggest how each program might be conceived and run by the community. The Professional Consultants in each of the above fields should be from the immediate community and should take part in the planning of and be responsible for discipline in the center. If help is needed by a community in advising or supplying a professional consultant in any of the above fields such can be obtained by writing your Regional Office in Atlanta, Georgia.

Most criticisms heard from physicians and dentists in this region regarding last summer's programs were mainly concerned with the fact that physicians and dentists were not consulted early in the planning phases of the individual local programs and that local medical societies and groups were not informed as to what were the goals of Head Start. This is written in an effort to overcome these faults. Local sponsors of child development programs should not begin a Head Start Center without first appointing a medical director. He should be asked to assist in planning the structure of that center. His ideas concerning the following should be particularly solicited:

1. Availability of personnel for consultation and emergency calls.
2. The necessity of a written permission form from each parent for supervision of each child's medical care.
3. His acceptance and endorsement of the medical guidelines for adequate medical screening of the participating children.
4. His endorsement of placing placards describing the emergency care of accidents and poisoning where they will be most readily available to the teacher or supervisor responsible for the daily care of the children.
5. The use of nurses aides and other health-related professional personnel in the screening of the children. A considerable portion of the screening of the children can be carried out by properly trained individuals and in each case their competence should be evaluated by the medical director of each Head Start Center.
6. His availability for health instructions to staff and parents plus his endorsement of the psychological, nutritional and medical record keeping of the center.
7. The time and place of the screening examinations and the conduct of the follow-up and emergency medical care of the children.
8. The time and place of immunization and laboratory screening procedures.

A dental director should also be consulted early in the program's planning, particularly as to the adequacy of the guide lines to be followed in the dental examination, treatment and follow up. The dentist should also decide to what extent health-related professional personnel should be used.

Communities should plan comprehensive health services for all HEAD START Child Development Programs. Funds from the Office of Economic Opportunity should be used only to meet health needs that cannot be met effectively by existing local resources. Funds from the Office of Economic Opportunity should not be used to provide services to children from prosperous homes, however, HEAD START Child Development projects applying to the Office of Economic Opportunity for financing must submit a plan outlining how the project will utilize existing resources, provide comprehensive and coordinated care, maintain high quality standards, and involve the parents of the children in the project planning.

The applicant must show all existing resources which have been evaluated or are available locally to meet the health needs of these children. To do this it will be necessary to investigate local school health programs, financial assistance available under both the 1965 amendments to the Social Se-

(Continued on Page 690)

(Continued from Page 689)

curity Act, the aid to dependent children programs, and state services for crippled children. It is also essential to check inpatient and out-patient facilities of public and private hospitals, medical schools and teaching hospitals, and the local health department programs. The applicant should clearly and specifically show any deficiencies in utilization of existing health care resources. On the basis of this analysis, HEAD START programs can be planned to more effectively utilize existing resources and develop additional services as required.

The HEAD START health program must provide comprehensive, continuous health care and supervision. It should contain appropriate means for coordinating all types of local health services and for planned interaction between health and other social services. The scope of the plan should include preventive, diagnostic, curative, and rehabilitative services for the children. The following at least should be arranged for—or provided directly—with the Office of Economic Opportunity's funds when they are not available through existing programs:

Overall health supervision of children who are well.

Immunizations.

Out-patient treatment of acute and chronic illnesses.

Comprehensive dental care, including preventive dental education.

Eye examinations as indicated by the medical director, including eye glasses if needed.

Speech and hearing examinations and provision of treatment, if needed.

Psychological evaluation and counseling.

High quality care can only be assured by gaining the participation and cooperation of qualified members of the medical, dental, psychological and nursing professions in the community. The plan must contain a means for assuring that follow-up services will be carried through. It is essential that continuing responsibility for the health needs of an individual child or family attending a Center must rest clearly with a single professional or a small, well-defined group of professionals. It is also essential that the staff of the HEAD START Child Development Center become the health advocate for the child. In this role the staff will see to it that needed services are actually available to the child and that the child, in turn, gets any care needed. The Center's nurse can act as liaison between parents, the Center, doctors and medical agencies. The nurse can also take the lead in teaching proper health habits and the rudiments of general standards of sanitation to both children and parents.

The health care to be provided must be made as accessible as possible by careful planning. Facilities and medical staff should be located in needy areas, or transportation to reach them provided. Much of the program can actually be carried on at the HEAD START Child Development Center. This has the additional advantage of keeping the professional health staff actively involved in the continuing work of the Center. Services should be provided at hours convenient to the patients and their families. The plan should try to remove any existing barriers to proper health care, particularly the impersonal quality that so often characterizes health services available to the poor. So that there will be no misunderstanding about the diagnosis and need for further care, every effort should be made to encourage a parent to accompany the child on his visits for care.

It should be emphasized that the responsibility for providing and coordinating health services in any HEAD START plan must be in the hands of these with the professional competence to meet the high standards which have been set for the program. It is essential that a medical director be designated at the earliest possible moment in the planning stage. Health personnel and professional groups should also have a chance to take part in planning. This is important, since so

many of the Center's services will come from them. Health services should be organized and coordinated to respond to the needs and desires of the groups to be served.

The agencies and personnel to meet these requirements will vary by community. They might include official health agencies, medical schools, voluntary and public hospitals and group practice prepayment plans and their staffs.

In some instances where no physicians or dentists are available it may be possible to send a medical or dental team into such an area in mobile clinics equipped with examination, laboratory and treatment facilities and manned by a physician, dentist and whatever health-related professions personnel deemed necessary by the local HEAD START medical director. It is estimated that each of the Southeastern region states will need from two to three such mobile units. The medical guidance in these cases could be secured from the nearest medical school and/or the nearest county medical and dental societies.

It should be specifically noted that a Head Start program is to be conceived, implemented and conducted by the Community which it serves. Organizations which had programs last summer or Community Action Agencies can apply for Head Start grants. In other localities any of the following may apply for funds:

1. Local health agencies
2. School boards
3. College or universities
4. Private non-profit organizations (settlement houses, women's clubs, fraternal groups, charitable and religious organizations) and institutions of higher learning.

From this it is clearly seen that each program will be organized and conducted by individuals living and practicing their professions in the community in which the center is located.

PROJECT—HEAD START

SUMMARY OF THE WORK CARRIED OUT LAST SUMMER

(Figures apply to total child development programs)

State	Number Grants	Number Centers	Number Children	Federal Cost	Non-Federal Cost	Total Cost
ALABAMA	59	288	14,028	$2,068,393	$289,522	$2,357,915
FLORIDA	41	346	17,980	$2,349,379	$346,987	$2,696,366
GEORGIA	100	379	18,588	$2,898,508	$406,511	$3,305,019
MISSISSIPPI	46	284	21,347	$4,152,242	$427,684	$4,579,926
SO. CAROLINA	39	262	13,840	$1,933,891	$222,088	$2,155,979
TENNESSEE	67	761	28,183	$4,120,910	$512,257	$4,633,167

now...introducing a **new** high-strength dosage fo

SIGNEM

A 'MAXIMUM SECURITY' ANTIBIOTIC*

* THE BROAD RANGE DEPENDABILITY OF TETRACYCLINE
long established as the broad-spectrum agent of first choice in a wide variety of infections

* WITH THE ADDED SECURITY OF MEDIUM-SPECTRUM REINFORCEMENT
triacetyloleandomycin is highly active against the common 'coccal' pathogens, including certain strains of staphylococci resistant to penicillin and tetracycline

* ESPECIALLY VALUABLE IN U.R.I.
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* NOW AVAILABLE IN NEW STRENGTH FOR NEW CONVENIENCE AND ECONOMY
Signemycin 375—high-potency capsules for simpler administration, greater patient economy

YCIN® 375

(tetracycline 250 mg. triacetyloleandomycin 125 mg.)

Indications: Indicated in the therapy of acute severe infections caused by susceptible organisms and primarily by bacteria more sensitive to the combination than to either component alone. In any infection in which the patient can be expected to respond to a single antibiotic, the combination is not recommended. Signemycin should not be used where a bacteriologically more effective or less toxic agent is available. *Triacetyloleandomycin, a constituent of Signemycin, has been associated with deleterious changes in liver function.* See precautions and adverse reactions.

Contraindications: Contraindicated in individuals who have shown hypersensitivity to any of its components. Not recommended for prophylaxis or in the management of infectious processes which may require more than 10 days of continuous therapy. If clinical judgement dictates therapy for longer periods, serial monitoring of liver function is recommended. Not recommended for subjects who have shown abnormal liver function tests, or hepatotoxic reactions to triacetyloleandomycin.

Precautions and Adverse Reactions: Triacetyloleandomycin, administered to adults in daily oral doses of 1.0 gm. for 10 or more days, may produce hepatic dysfunction and jaundice. Adults requiring 3 gm. of Signemycin initially should have liver function followed carefully and the dosage should be reduced as promptly as possible to the usual recommended range of 1.0 to 2.0 gm. per day. Present clinical experience indicates that the observed changes in liver function are reversible after discontinuation of the drug.

Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacetyloleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.

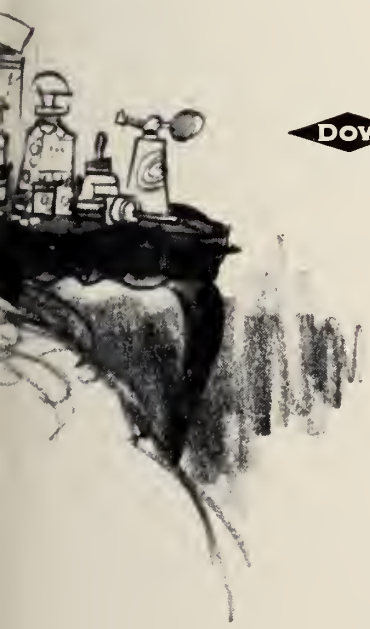
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Division, Chas. Pfizer & Co., Inc.
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New York, N.Y. 10017



If you can hang on for a few minutes, Doctor, I'm sure I'll start coughing again.

Some patients don't realize there's more to a cough than meets the ear.
If it's the useless, exhausting type of cough that often accompanies respiratory infection or allergy, you can provide prompt relief with Novahistine DH. Its decongestant-antitussive action controls frequency and intensity of cough spasms without abolishing cough reflex. And the fresh, grape flavor of Novahistine DH appeals to children and adults alike.
When your diagnosis is bronchitis, complicated by thick tenacious exudates, Novahistine Expectorant is particularly useful. It not only provides decongestive action and controls the cough, but also encourages expectoration, thus easing bronchial constriction and obstruction.
Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Ambulatory patients should be advised that drowsiness may result. Continuous dosage over an extended period is contraindicated since codeine phosphate may cause addiction.
Each 5 ml. teaspoonful of Novahistine DH contains codeine phosphate, 10 mg. (Warning: may be habit forming); phenylephrine hydrochloride, 10 mg.; chlorpheniramine maleate, 2 mg.; chloroform (approx.), 13.5 mg.; l-menthol, 1 mg. (Alcohol 5%). Each 5 ml. of Novahistine Expectorant contains the above ingredients and, in addition, glyceryl guaiacolate, 100 mg.

NOVAHISTINE® DH
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Program

of the

105th ANNUAL SESSION

of the

MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

MOBILE :—: MUNICIPAL AUDITORIUM

APRIL 21, 22, 23, 1966

General Information

All business sessions of the meeting will be held at the Municipal Auditorium.

All Scientific sessions will be held at the Municipal Auditorium.

HOST TO THE ASSOCIATION

The Mobile County Medical Society

OFFICERS

George W. Newburn, Jr., M. D., President
Neal S. Flowers, M. D., President-elect
Herbert V. Allen, M. D., Secretary
William P. Coats, M. D., Treasurer

PROGRAM COMMITTEE

James G. Donald, M. D., Chairman
William J. Atkinson, M. D., Chairman, Department of Medicine, Mobile General Hospital
Howard S. J. Walker, Jr., M. D., Chairman, Department of Surgery, Mobile General Hospital
O. M. Otts, M. D., Chairman, Department of Ob-Gyn, Mobile General Hospital

SCIENTIFIC EXHIBITS

Charles J. Hollis, M. D., Mobile

The Mead Johnson Company will present a $200 Aesculapius Award for the best Scientific Exhibit. A committee will be appointed by the President, Dr. James G. Donald, as judges.

THE FIFTY YEAR CLUB

As has been the custom since 1948, certificates of distinction are to be awarded to physicians of the state who have practiced their profession for 50 years. The presentation will be made on Friday morning. Those to whom the certificates will be awarded are:

Henry Beechum Burdeshaw Dothan
John Thomas Ellis Dothan
Lewis Herschel Hamner Camp Hill
William Campbell Hannon Mobile
William Perry Johnson Hamilton
James Orville Morgan Gadsden
Fred Dawson Reynolds Montgomery
Cecil Hubert Ross Mobile
William Llewellen Staggers Benton
Lucius Lamar Terry Sylacauga
Jesse James Walls Alexander City
Jerre Watson Anniston
Lewis Anthony Windham Luverne

PROGRAM

THURSDAY, APRIL 21, 1966
Municipal Auditorium

J. O. Finney, Sr., M. D., President-elect, Presiding

Call to order

Introduction: J. O. Finney, Sr., M. D.

Invocation—The Rev. Dr. Paul B. McCleave

9:05 A. M.

Welcome Addresses—

Mayor Joe Langan, Mobile
George W. Newburn, Jr., M. D., Mobile, President, Mobile County Medical Society.

ORIENTATION PROGRAM

J. O. Finney, Sr., M. D., President-elect, Presiding

9:15 A. M.

County Medical Society Organization and Activities, William L. Smith, M. D., Montgomery

9:25 A. M.

State Board of Censors, Robert Parker, M. D., Montgomery

9:35 A. M.

State Board of Health and County Affiliates, Ira L. Myers, M. D., State Health Officer, Montgomery

9:45 A. M.

BREAK—VIEW EXHIBITS

10:00 A. M.

Committees of the Association, W. J. Atkinson, Jr., M. D., Mobile

10:10 A. M.

Ethics, Tinsley R. Harrison, M. D., Birmingham

10:20 A. M.

Medicare, M. Vaun Adams, M. D., Mobile

10:30 A. M.

AMPAC, E. B. Glenn, M. D., Birmingham

10:40 A. M.

Blue Cross-Blue Shield, William E. Lawrence, M. D., Birmingham

10:50 A. M.

The Medical College of Alabama, Present and Future, Dean S. Richardson Hill, Birmingham

11:00 A. M.

Woman's Auxiliary, Mrs. James F. Crenshaw, President

11:05 A. M.

Medicine and Religion, The Rev. Dr. Paul B. McCleave

11:35 A. M.

President's Message, James G. Donald, M. D.

SCIENTIFIC PROGRAM

THURSDAY, APRIL 21, 1966

Municipal Auditorium

Howard S. J. Walker, Jr., M. D.,
Chairman, Department of Surgery,
Mobile General Hospital,
Presiding

2:00-2:20 P. M.

Carcinoma of the Lung—Personal Experience with 1600 Patients

Orville W. Clayton, M. D., Birmingham

2:20-2:40 P. M.

Modern Concepts in the Management of Gout

Gene V. Ball, M. D., Birmingham

2:40-3:00 P. M.

Anuria Due to Shock or Obstruction

Jack Hyman, M. D., and John Fridge, M. D., Mobile

3:00-3:20 P. M.

The Use of Estrogens in the Post-Menopausal Female with Special Reference to Coronary Disease

T. Albert Farmer, Jr., Assistant Professor of Medicine, University of Alabama School of Medicine, Birmingham

3:20 P. M.

BREAK—VIEW EXHIBITS

3:30-3:50 P. M.

Use of the Riechert-Mundinger Stereotactic Apparatus in the Treatment of Parkinson's Disease

William Patton, M. D., Mobile

3:50-4:30 P. M.

Pancreatitis: Diagnosis and Treatment

James T. Priestley, M. D., President, American College of Surgeons, Rochester, Minnesota

4:30-5:00 P. M.

Neo-Natal Mortality

Herschell P. Bentley, Jr., M. D., Chairman, Department of Pediatrics, Medical College of Alabama, Birmingham

FRIDAY, APRIL 22, 1966

James G. Donald, M. D., Presiding

Invocation—The Rev. Dr. Paul B. McCleave

9:00-9:20 A. M.

Intrauterine Devices

O. Thomas Bolding, M. D., Birmingham

9:20-9:50 A. M.

Problems Associated with Gastric Surgery

James D. Hardy, M. D., Professor and Chairman, Department of Surgery, University of Mississippi Medical Center, Jackson, Mississippi

9:50-10:10 A. M.

Preventable and Avoidable Cancers, and Cancers Arising from Personal Indifference

Wendell G. Scott, M. D., Past President, American Cancer Society, St. Louis, Missouri

10:10-10:20 A. M.

BREAK—VIEW EXHIBITS

10:20-10:50 A. M.

Charles Hudson,
President-elect, AMA,
Cleveland, Ohio

10:50 A. M.

Recognition of Fifty Year Club, William Crawford Gorgas Award, Douglas L. Cannon Medical Reporter Award, William Henry Sanders Award, Recognition of Fraternal Delegates

11:00 A. M.

JEROME COCHRAN LECTURE: **The Pathogenesis and Surgical Treatment of Gastric Ulcer**

Lester Dragstedt, M. D., Research Professor of Surgery, University of Florida, Gainesville, Florida

12:30 P. M.

LUNCH

FRIDAY AFTERNOON
APRIL 22, 1966

William J. Atkinson, M. D., Chairman, Department of Medicine, Mobile General Hospital, Presiding

2:00-2:20 P. M.

Shock in CNS Injuries

Frank Cope, Jr., M. D., Mobile

2:20-2:50 P. M.

Vascular Disorders

E. Stanley Crawford, M. D., Associate Professor of Surgery, Baylor University College of Medicine, Houston, Texas

2:50-3:10 P. M.

Shock in Coronary Occlusion

Gus G. Casten, M. D., Birmingham

3:10-3:40 P. M.

Bacteremic Shock

Richard Lilleihei, M. D., Associate Professor of Surgery, University of Minnesota, Minneapolis, Minnesota

3:40 P. M.

BREAK—VIEW EXHIBITS

4:00-5:00 P. M.

PANEL ON "SHOCK"

Moderator, James D. Hardy, M. D., Jackson, Mississippi

Panelists:

Richard Lilleihei, M. D., Minneapolis, Minnesota

E. Stanley Crawford, M. D., Houston, Texas

Gus G. Casten, M. D., Birmingham

W. Sterling Edwards, M. D., Birmingham

SATURDAY MORNING

APRIL 23, 1966

James G. Donald, M. D., President, Presiding

Business meeting of the Association sitting as the Board of Health of the State of Alabama.

(1) Report of the Board of Censors

(2) Revision of the Rolls
- (a) County Societies;
- (b) Counsellors;
- (c) Correspondents;

(3) Election and Installation of Officers

(4) Presentation of Past President's Plaque

ADJOURNMENT

OTHER EVENTS

WEDNESDAY, APRIL 20, 1966

Exhibitors Party

Cocktail Party for Exhibitors—Municipal Auditorium—4:00 P. M. to 5:00 P. M. Physicians are invited.

Golf Tournament

Golf Tournament—Walter L. Hogan, Jr., M. D., Chairman

Mobile Country Club

Alumni Association, Medical College of Alabama

The Alumni Association, Medical College of Alabama will have a reception at 7:00 P. M., and dinner at 8:00 P. M., at the Mobile Country Club. Installation of new officers will be made at the dinner.

Alabama Thoracic Society and Alabama Tuberculosis Association

All physicians are invited to attend a Symposium sponsored by the Alabama Thoracic Society and The Alabama Tuberculosis Association.

THURSDAY, APRIL 21, 1966

Medicine and Religion

Luncheon—12:30

Evening of Entertainment

The Mobile County Medical Society will be hosts with an "Evening of Entertainment" at the Municipal Auditorium. Tickets will be available at the registration desk.

FRIDAY, APRIL 22, 1966

ALAPAC Luncheon

The Alabama Political Action Committee will sponsor a luncheon at the Municipal Auditorium, 12:30 P. M. Guest speaker will be U. S. Representative Durward Hall, M. D. Tickets will be available in the Lobby of the Auditorium.

Scroll and Key Club

The Scroll and Key Club will entertain at the Mobile Country Club with cocktails at 6:00 P. M., Dinner at 7:00 P. M. and a Dance at 9:00 P. M. Tickets will be available in the Lobby of the Auditorium.

Alabama Radiological Society

The Alabama Radiological Society will hold its semi-annual meeting at a luncheon, 1:00 P. M., at the Admiral Semmes Hotel. Wendell G. Scott, M. D., Past President, American Cancer Society, St. Louis, Missouri, will be guest speaker.

PROGRAM

of the

42nd Annual Convention

of the

WOMAN'S AUXILIARY

to the

MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

SHERATON BATTLE HOUSE HOTEL

MOBILE, ALABAMA :—: APRIL 21, 22, 1966

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WAMASA News:
Editor: Mrs. Harry Till Montgomery

(Continued on Page 702)

A Key Site of Action of the Protoveratrine A in Salutensin

"The main function of the carotid sinus is regulation of the blood pressure...."[1]

The veratrum component of Salutensin acts here (and in the myocardium), initiating "...a reflex fall in blood pressure through a generalized vasodilation and fall in heart rate."[2]



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References: 1. Editorial: JAMA *191*:592 (Feb. 15) 1965. 2. Meilman, E., in Moyer, J.H.: Hypertension, Philadelphia, W. B. Saunders Company, 1959, p. 395.

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(Continued from Page 699)

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ACKNOWLEDGEMENTS

The Woman's Auxiliary gratefully acknowledges the Greater Mobile Tourist and Convention Commission for their assistance in registration and cover illustration.

PROGRAM

WEDNESDAY, APRIL 20, 1966

2:00-5:00 P. M.—Pre-Convention Registration, Sheraton Battle House Hotel Lobby—Registration Fee $2.00

Archives and Exhibits entries accepted until deadline Thursday, April 21, 4:00 P. M. Displays on view in Hospitality Rooms 210-212 of Sheraton Battle House Hotel.

THURSDAY, APRIL 21, 1966

8:00 A. M.-3:00 P. M.—Registration, Lobby of the Sheraton Battle House Hotel, Registration Fee: $2.00

8:00 A. M.—Pre-Convention Board Meeting—Dutch Breakfast ($2.00)—Andrew Jackson Room, Sheraton Battle House Hotel

9:00 A. M.—First General Session
Andrew Jackson Room, Sheraton Battle House Hotel

Call to Order—Mrs. James F. Crenshaw

Invocation—Mrs. C. W. Daniels, Mobile

Auxiliary Pledge—Mrs. William L. Smith

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation, and ever sustain its high ideals."

Welcome—Mrs. G. William Wiles, President, Mobile County Auxiliary

Introduction of guests—Mrs. Crenshaw

Convention Rules of Order—Mrs. W. R. Sutton, Parliamentarian

Report of Reading Committee—Mrs. R. K. Wilson
First Report of Credentials Committee—Mrs. R. L. Brier

Annual Report of Officers:
President: Mrs. James F. Crenshaw
President-Elect: Mrs. Ira B. Patton

***Fair Warning:
Our Time Gal's a CHARMER,
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But a report past two minutes,
Will get her "Beep, Beep."

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Marshall—Mrs. M. T. Hunt
Shelby—Mrs. W. E. Stinson
Talladega—Mrs. F. G. Wright

11:00 A. M.—First Report of Nominating Committee—Mrs. Walker Sorrell
Memorial Service—Mrs. Cecil E. Kimbrough
Announcements—Mrs. Curtis Smith

RECESS

12:00 Noon—Buses load, entrance Sheraton Battle House Hotel for Mobile Country Club

12:30 P. M.—Mobile Country Club
Dutch Luncheon honoring Mrs. William G. Thuss, Sr., President, Woman's Auxiliary to the Southern Medical Association, and Past Presidents of the Woman's Auxiliary to the Medical Association of the State of Alabama, Mrs. James F. Crenshaw, presiding.

Invocation—Mrs. C. W. Daniels

Introduction of Guests—Mrs. Crenshaw

Greetings from Southern Medical—Mrs. William G. Thuss, Sr., Birmingham

AMA-ERF Awards—Mrs. B. H. Johnson

Door Prizes—Mrs. Julian Lewis

Announcements—Mrs. Curtis Smith

Historic Tour of Mobile—Buses load at entrance to Mobile Country Club.

The Mobile County Medical Society will be hosts with an "Evening of Entertainment" at the Municipal Auditorium.

FRIDAY, APRIL 22, 1966

8:00 A. M.-12:00 Noon—Registration, Lobby Sheraton Battle House Hotel—Registration Fee: $2.00

9:00 A. M.—Second General Session
Andrew Jackson Room, Sheraton Battle House Hotel

Call to Order—Mrs. James F. Crenshaw

Invocation—Mrs. E. L. Bryant, Mobile

Introduction of Guests—Mrs. Crenshaw

Annual Report of Officers continued:

SOUTHWEST DISTRICT—Mrs. A. D. Henderson
Baldwin—Mrs. Charles Sherman
Dallas—Mrs. J. W. Moore
Mobile—Mrs. G. William Wiles

SOUTHEAST DISTRICT—Mrs. C. N. Matthews
Coffee—Mrs. John Kimmey
Covington—Mrs. J. J. Moore
Elmore-Tallapoosa—Mrs. J. L. Bennett
Geneva—Mrs. R. L. Martin, Jr.
Houston—Mrs. L. L. Johnson
Montgomery—Mrs. Richard Garrett
Pike—Mrs. W. P. Stewart

Historian—Mrs. R. A. Dillard

Second Report of Credentials Committee—Mrs. R. L. Brier

9:50 A. M.—New Business

Recommendations from Executive Board—Mrs. Crenshaw

Revisions—Mrs. John Kimmey

Presentation of Budget—Mrs. J. P. Brooke

Election of 1966-67 Nominating Committee

Report of Nominating Committee—Mrs. Walker Sorrell

Election of Officers

Installation of Officers—Mrs. Richard A. Sutter

Presentation of President's Pin and Gavel—Mrs. Crenshaw

Inaugural Address—Mrs. Ira B. Patton

Introduction of Committee Chairmen for 1966-67—Mrs. Patton

Post-Convention Board Meeting—Sheraton Battle House Hotel

Announcements—Mrs. Curtis Smith

RECESS

12:00 Noon—Crystal Ballroom, Sheraton Battle House Hotel

Luncheon honoring Mrs. Richard A. Sutter, President, Woman's Auxiliary to the American Medical Association. Mrs. G. William Wiles, President, Mobile County Medical Auxiliary, presiding.

Invocation—Mrs. E. L. Bryant

Introduction of Guests—Mrs. Wiles

Address by National President—Mrs. Richard A. Sutter

Fashion Show by Reiss Brothers—Models, members of the Mobile County Auxiliary

Archives & Exhibits Awards—Mrs. M. C. Barrett

Door Prizes—Mrs. Julian Lewis

Announcements—Mrs. Ira B. Patton

Adjournment—Mrs. James F. Crenshaw

The Scroll and Key Club will entertain at the Mobile Country Club.

CONVENTION RULES OF ORDER

1. All persons appearing on the program shall be seated in a reserved section at the front of the room.
2. Members of the voting body shall wear badges at all sessions of the convention.
3. When addressing the chair, the member shall rise, give her name and name of her county auxiliary.
4. Unless notified to the contrary, each speaker shall be limited to two minutes and shall not speak more than twice on any question.
5. A timekeeper will notify each speaker when two minutes are up.
6. All motions shall be written, signed and presented to the Recording Secretary.
7. Reports shall be read only by person making the report or her appointed delegate.
8. Visitors are welcome to all sessions of the convention but are requested to register and to sit apart from the voting body.



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THE JOURNAL
of
THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA
Published Under the Auspices of the Board of Censors

Volume 35 March, 1966 No. 9

Jejunal Diverticulitis

W. N. Viar, M. D.
J. M. Donald, Jr., M. D.

Birmingham, Alabama

Jejunal diverticulosis is well established as a pathological entity, but rarely presents as a clinical problem. Sommervet in 1794 and Voigtel in 1804 described jejunal diverticula found at autopsy while Cooper in 1804 and Osler in 1881 were the first to mention these lesions in the English literature.[1] Gordinier and Sampson in 1906 reported the first case encountered and recognized in a living patient.[2]

True impetus toward a more acute awareness of this lesion was given by Case in 1920 when he reported four cases recognized in 6,847 radiological examinations of the small intestine.[3] This report stimulated numerous studies both by radiologists and pathologists to determine the incidence of jejunal diverticula. Figures ranged from 0.06 per cent to a high of 1.3 per cent obtained by Rosedale who used air insufflation of the jejunum at post mortem examination to more readily identify obscure diverticula.[4]

Recent encounter of three cases of symptomatic jejunal diverticula stimulated our interest in this subject and partial review of the literature indicates that further emphasis would be worthwhile.

Case Reports

Case No. I: E. A., a 71 year-old white male entered the hospital on November 29, 1961, with a one month history of abdominal pain. He described this as a steady pain, worse in the left upper quadrant but without radiation. There was associated nausea but no vomiting. There was no hematemesis or melena and the pain was not relieved by ingestion of food. He had noted a ten pound weight loss over the previous six months. Examination revealed a blood pressure of 110/60 mm. Hg. The pulse rate was 70/min. and regular. Respirations were 24/min. and the temperature was 98.6° F. Other than moderate cardiac enlargement and a murmur of aortic stenosis, pertinent physical findings were limited to the abdomen. There were no surgical scars or distention. Palpation revealed moderately severe tenderness in the mid abdomen but no rebound tenderness. Bowel sounds were normal. There were no palpable organs or masses.

Work-up included a normal hemogram and urinalysis. The fasting blood sugar was 102 mg. per cent, and the BUN was 21 mg. per cent. A cholecystogram was negative and

an upper G. I. series revealed only jejunal diverticula, the largest measuring 1.5 cm. There was no mucosal edema, spasm or obstruction noted radiographically.

After evaluation by a cardiologist, the patient was explored and found to have numerous diverticula of the proximal jejunum with acute inflammation about the largest. A 34 cm. segment of jejunum was resected and intestinal continuity re-established by end-to-end anastomosis. The patient made an uneventful recovery and was discharged home on the tenth postoperative day. He has remained asymptomatic. Microscopic examination showed considerable edema and subacute inflammation of the mucosa and submucosa but there was no actual ulceration.

Case No. II: H. M., a 91 year-old white female was admitted to the hospital on February 5, 1964, with a twelve hour history of abdominal pain rapidly increasing in severity. There was no antecedent abdominal distress and the acute episode was not accompanied by nausea, vomiting, diarrhea, or constipation.

Examination revealed blood pressure of 190/90. Pulse rate 84 per minute and regular. Respiratory rate 24 per minute. Temperature 100.2° F. Pertinent physical findings were limited to the abdomen where the patient was found to have marked lower abdominal tenderness, both direct and rebound, the left being greater than the right. Bowel sounds were hypoactive.

Her white blood cell count was 17,900 with 86 polymorpho-nuclears, 6 lymphocytes, 4 monocytes and 1 stab. Her hemoglobin was 13.6 grams or 88 per cent. The urinalysis was negative.

Exploratory laparotomy revealed acute jejunal diverticulitis with turbid peritoneal fluid and fibrinous exudate over the serosa of the small intestines. This cultured Escherich Coli. No actual perforation was noted grossly or microscopically. A 32 cm. segment of jejunum containing numerous diverticula measuring from 1.5 to 4 cm. was resected with end-to-end anastomosis. The patient was discharged on the 14th day after a benign postoperative course and has remained symptom free.

Case No. III: D. W., a 67 year-old white male entered the hospital July 28, 1964. At that time he gave a two year history of vague progressive epigastric pain with radiation to the right costal margin. There was associated "gaseousness" with nausea but no vomiting. The pain usually came on ten to twenty minutes following meals. On occasion antacids would give relief up to one hour. He also complained of occasional retrosternal burning in the recumbent position.

The past history was pertinent in that the patient had had a duodenal ulcer since 1928. A hiatal hernia which was asymptomatic was discovered in 1956. Because of intractability, the patient underwent sub-diaphragmatic vagotomy and pyloroplasty with hiatal hernia repair in August, 1959. Jejunal diverticula were noted at this time and felt to be asymptomatic. The patient returned in 1962 with a large ventral hernia. This was repaired using Marlex mesh. Again, the jejunal diverticula were noted.

Exam on the patient's most recent admission was unrevealing except for the previous abdominal incisions which were now healed without evidence of herniation.

An upper G. I. series showed a recurrent hiatal hernia plus extensive jejunal diverticula. (Fig. I) On July 29, 1964, the patient underwent repair of his recurrent hiatal hernia and resection of the 41 cm. segment of jejunum. Microscopic examination showed vascular congestion with chronic inflammatory exudate and fibrinous deposition along the serosal surface.

The patient did well and although the follow-up period is quite short, he is now symptom free.

Discussion

Diverticula of the jejunum are of two types, congenital and acquired. Congenital diverticula are classically in the younger age



Figure 1

group, are usually single and occur along the anti-mesenteric border consisting of all layers of the intestinal wall. They are quite rare and mentioned here only for completeness.

Acquired diverticula occur in the older age group, are usually multiple, occur along the mesenteric border and represent a true herniation of mucosa and submucosa through the muscularis.

As in colonic diverticula, acquired jejunal diverticula herniate at the site of penetration of the muscularis by blood vessels. Altmeier,[5] in his excellent paper, has proposed an autonomic imbalance of the small bowel innervation as the possible basic pathogenetic defect. This imbalance leads to a functional, as opposed to a mechanical, obstruction with an increase in intraluminal pressure and subsequent formation of the diverticula.

It is felt by most authors that jejunal diverticula are rarely symptomatic. This is explained by the fact that (a) the jejunal contents are liquid and unlikely to become inspissated, (b) the contents are relatively bacteria-free and (c) the ostia of jejunal diverticula are usually widely patent and rarely become obstructed. Baskin and Mayo[6] reviewed 87 cases encountered clinically at the Mayo Clinic. Of these, 10.4 per cent had complications of a serious nature, whereas 28.7 per cent complained of gaseous dyspepsia and mild abdominal discomfort for which no other cause could be found. The remaining 60.9 per cent were felt to be asymptomatic.

Complications of jejunal diverticula, as mentioned, are rare but unfortunately present the problem with which the surgeon is most acutely concerned.

These complications may be summarized as follows:

I. Obstruction

II. Inflammation

III. Hemorrhage

IV. Malabsorption syndrome

V. Miscellaneous (foreign body impaction, neoplastic change, enterolith formation.)[5]

Some disagreement exists as to which symptom complex is more common, diverticulitis or obstruction. If one views the problem as Altmeier and his group, who subdivide the obstructive complaints into chronic dyspeptic symptoms (jejunal dyskinesia[5]) and acute mechanical obstruction, obstruction would seem to be the most common.

The fact that the symptomatology of complicated jejunal diverticula is entirely nonspecific is substantiated by our three cases. One presented as an acute intra-abdominal inflammation, another as a steadily progressing clinical picture of severe abdominal discomfort and the third as chronic, vague dyspeptic symptoms. In truth, they represent the entire spectrum of jejunal diverticulitis.

The diagnosis of jejunal diverticula is made by either radiological means or at laparotomy.

Treatment may be summarized as follows: For the jejunal diverticula encountered incidentally on X-ray studies or at operation, no specific therapy is indicated. The patient who presents with dyspeptic symptoms for which no other cause can be found, non-operative means such as bland frequent small feedings and anti-cholinergic drugs should be tried. When symptoms persist or progress consideration of surgical resection should be given. In the rare case of malabsorption syndrome associated with macrocytic anemia and steatorrhea, a course of oral tetracycline therapy seems warranted.[5]

Obstruction, hemorrhage, and diverticulitis should be managed surgically, and resection with end-to-end anastomosis is the treatment of choice. The technique of air insufflation of the jejunum, as advocated by Mayo, et al,[7] should be kept in mind when exploratory laparotomy for obscure gastrointestinal hemorrhage is undertaken.

Summary

Three cases of symptomatic jejunal diverticula, representing extremes of the spectrum of jejunal diverticulitis, are presented. A brief appraisal of pathology, pathogenesis, complications and treatment is given. Because of the varied clinical pictures, which jejunal diverticula may present, each physician and especially surgeons are urged to recognize these lesions as such, rather than as a medical curiosity. An increasing geriatric population is almost certain to make this disease a more frequent and important clinical problem.

Bibliography

1. Kubota, Nobutaka, Yee, Samuel L.: Jejunal Diverticulitis with Inflammation and Peritonitis, Archives of Surgery, 81: 45-49, 1960.

2. Gordinier, H. C. and Sampson, J. A.: Diverticulitis (Not Meckel's) Causing Intestinal Obstruction: Multiple Mesenteric (Acquired) Diverticula of the Small Intestine, J. A. M. A. 46: 1585-1590, 1906.

3. Case, T. J.: Diverticula of Small Intestines Other Than Meckel's Diverticulum, J. A. M. A., 75: 1463-1470, 1920.

4. Rosedale, R. S. and Lawrence, H. R.: Jejunal Diverticulosis, American Journal of Surgery, 34: 369-373, 1936.

5. Altmeier, W. A., Bryant, L. R. and Walsin, J. H.; The Surgical Significance of Jejunal Diverticulosis, Archives of Surgery, 86: 732-744, 1963.

6. Baskin, R. H., Jr. and Mayo, C. W.: Jejunal Diverticulosis: A Clinical Study of 87 Cases, Surgery Clinics of North America, 32: 1185-1196, 1952.

7. Mayo, C. W., Baskin, R. H., Jr., and Hagedorn, A. B.: Hemorrhagic Jejunal Diverticulitis, Annals of Surgery, 136: 691-699, 1952.

* * *

WHO WANTS THE CHEAPEST DRUG?

When a prescription contains a generic name, it is still incumbent on the pharmacist to dispense a drug he knows to be of the highest quality. Shall we give our patients the cheapest? Is it through no accident that cheap has come to mean inferior as well as inexpensive? When a reputable and well known house puts its name on a product, it has added something to it, and what may be its most important element. If we could be sure that our patients could get the same medication and save money while doing it, other arguments might not carry the day. But if there is a difference, then it is well worth it. Frank Cole, M. D., in *Nebraska State Medical Journal*, (50:507), October, 1965.



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Peachtree Hospital, located in Atlanta, Georgia, is a complete psychiatric, alcoholic and drug addiction treatment facility accredited by the Joint Commission on Accreditation of Hospitals ☐ The hospital has 65 beds, 47 of which are devoted to the care of psychiatric patients and 18 of which, in a separate area, are for patients with acute cases of chronic alcoholism or drug addiction ☐ Treatment procedures include psychotherapy, electroconvulsive shock therapy, subinsulin coma and chemotherapy ☐ *We will be pleased to provide further information upon request.*

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Hepatolenticular Degeneration (Wilson's Disease)

Amos C. Gipson, M. D.

Joseph E. Barrett, M. D.

Partlow State School

Tuscaloosa, Alabama

This condition, genetically transmitted as a simple recessive, is characterized by a decrease of copper in the blood stream due to inability of cerulo plasmin to bind the copper. The increased copper concentration damages the tissues of the liver, brain, and other organs. In the central nervous system the basal ganglia are principally affected but, to a lesser extent, the cortex, cerebellum, and other levels are also involved. There is a nodular cirrhosis of the liver. Most cases are not manifest until the second and third decades but onset in early childhood is reported on occasion.

Evidence of neurological involvement includes gross tremor, muscle spasms, Parkinsonism, rigidity, torticollis, dysarthria, dysphasia, convulsions and mental retardation. Most cases eventually show the Kayser-Fleischer ring, a brown or greenish-brown deposit of pigment in the cornea adjoining the sclera. It is most easily found on slit lamp examination.

The course of the disease is generally slow with the patient succumbing within 10 years. Rarely, cases may terminate in a few weeks or last as long as three or four decades.

Case Report

This patient was operated on for cholecystitis and cholelithiasis in 1960 and was found to have cirrhosis of the liver and atrophy of the right kidney in addition to the above.

The diagnosis was made on this patient by John McD. McGehee, M. D., of Mobile, Alabama, confirmed by slit lamp examination by him and here at Partlow School. Finding the Kayser-Fleischer ring by slit lamp examination is generally considered to be pathognomonic of Hepatolenticular degeneration.

This patient was having severe behavior difficulties until Dr. McGehee started him on penicillamine. After one month's therapy with this drug the behavior problems subsided considerably.

Rational treatment has evolved more or less concomitantly with the understanding of some of the metabolic abnormalities. The disease is hereditary but can be treated environmentally. Essentially an attempt is made to create negative copper balance by decreasing intake and increasing output.

Intake of copper is limited by a low-copper diet, which has been worked out in detail. Chocolate, nuts, dried fruits, sea (shell) food,



mushrooms, liver and cereals are to be completely avoided. The copper which is ingested can be largely removed by potassium sulfide taken with meals and the copper sulfide thus formed is excreted in the feces. The taste of the potassium sulfide is so bad it is difficult to get a mentally retarded child to take it.

Copper output is increased by various methods, including high protein diet, amino acids, cortisone and versenate, but BAL and penicillamine have been found by experience to be the most effective. BAL requires painful intramuscular injections and has caused skin rash, fever, exacerbations of the disease, hallucinations and coma in occasional patients. Penicillamine can be taken orally, seems safe and is available. Periodic blood counts, urinalysis and lens examinations for cataract are indicated.

Improvement often occurs only gradually and over many months. A short course of BAL and long-term penicillamine may be combined. It may be possible to prevent the disease if asymptomatic hypoceruloplasminemic children are treated. They can be found by testing all relatives of known patients with HLD.

The signs and symptoms of HLD are those of liver and nervous system damage. Death from liver failure is not uncommon.

This patient has a blank expression, speech which is very hard to understand, some tremor, rigidity of both arms and a slightly unsteady gait. He has had a few convulsions.

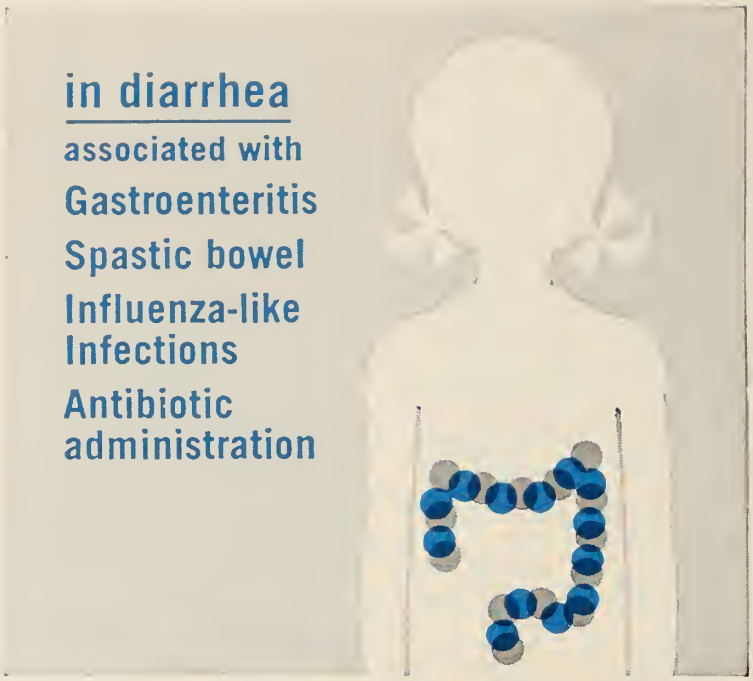
Laboratory Data: The examination of the blood is usually normal but there is usually an increase in copper excretion in the urine. These determinations are not available to us here.

Treatment: His diet consists of foods other than those listed above except for occasional cereals for breakfast and is receiving by mouth 1,000 mgs. (1 gm.) of penicillamine (cupramine) daily and is doing fairly well at the present time.

* * *

DANGER—BATHTUB AHEAD

Ill-advised statements and actions since the thalidomide phenomenon, aided by the unbalanced perspective given these statements in the lay press, have contributed to the public's apprehension—approaching hysteria—concerning the side effects of drugs. To the extent that this concern admonishes greater caution and alertness in the use of drugs, some good may be salvaged from the thalidomide tragedy. But to the extent that it deprives patients of useful new drugs or frightens a physician into withholding needed therapy from his patients, it is regrettable. We must not forget that there is no progress without risk, whether it be in the field of electricity, the motor car, the airplane, atomic energy, space exploration, or drugs. Even a bathtub can be perilous, as astronaut John Glenn discovered. Theodore G. Klumpp, M. D., in *Massachusetts Physician,* (28:207-208), June-July 1965.



normal activity...

promptly...



In children with diarrhea prompt symptomatic control is usually urgently indicated to relieve cramping and to prevent dehydration.

Lomotil halts precipitous progress through the intestines and controls diarrhea with notable promptness, safety and effectiveness.

Experimental evidence[1] has shown that Lomotil is more efficient in this regard than morphine without the latter's manifest disadvantages. In roentgenographic study[2] Lomotil slowed gastrointestinal propulsion within two hours.

At the same time, by diminishing overstimulation of the intestines, Lomotil relieves the abdominal cramps and discomfort so distressing to youngsters.

Lomotil gets children off toast and tea and back to normal diets and normal activity with gratifying celerity.

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Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride 2.5 mg.
(Warning: may be habit forming)
atropine sulfate 0.025 mg.

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial *daily dosages*, given in divided doses, until diarrhea is controlled, are:

Children:

3 to 6 months—3 mg. (½ tsp* t.i.d.)
6 to 12 months—4 mg. (½ tsp. q.i.d.)
1 to 2 years—5 mg. (½ tsp. 5 times daily)
2 to 5 years—6 mg. (1 tsp. t.i.d.)
5 to 8 years—8 mg. (1 tsp. q.i.d.)
8 to 12 years—10 mg. (1 tsp. 5 times daily)

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one fourth the therapeutic dose.

Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is an exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

1. Janssen, P. A. J., and Jageneau, A. H.: A New Series of Potent Analgesics: Dextro 2:2-Diphenyl-3-Methyl-4-Morpholinobutyryl-pyrrolidine and Related Amides. Part 1: Chemical Structure and Pharmacological Activity, J. Pharm. Pharmacol. 9:381-400 (June) 1957.

2. Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.

SEARLE

Research in the Service of Medicine

around the state



Dr. Robert K. Oliver (standing) explains the problems of the recalcitrant tuberculosis patient and the need for corrective state legislation to Dr. William Virgin (left) and Dr. Frank Phillippi, members of the Committee on Legislation.



Two members of the Board of Trustees, Dr. J. O. Finney, Sr., (left) and Dr. John Day Peake, give undivided attention to a discussion by representatives of the Alabama Radiological Society relative to billing practices to be followed under Part B of Title XVIII, Public Law 89-97 (Medicare).



Dr. Robert Adams, program chairman, Medical Society of Montgomery County is shown with Dr. Buris Boshell, Birmingham, speaker at the February meeting of the Society.



National legislative problems occupied the attention of the above group representing the Alabama Academy of Ophthalmology and Otolaryngology meeting in conjunction with the MASA Committee on Legislation. Clockwise around the table from left are: Dr. Louis Johnson, Dothan; Dr. James H. Farrior, Montgomery; Dr. John Allen Jones, Montgomery; Dr. John Nelson, Tuscaloosa; Dr. Karl Benkwith, Montgomery; Dr. Daniel L. Hagood, Montgomery; Dr. B. F. Jackson, Montgomery, and Dr. Davis F. Sellers, Mobile.

* * *

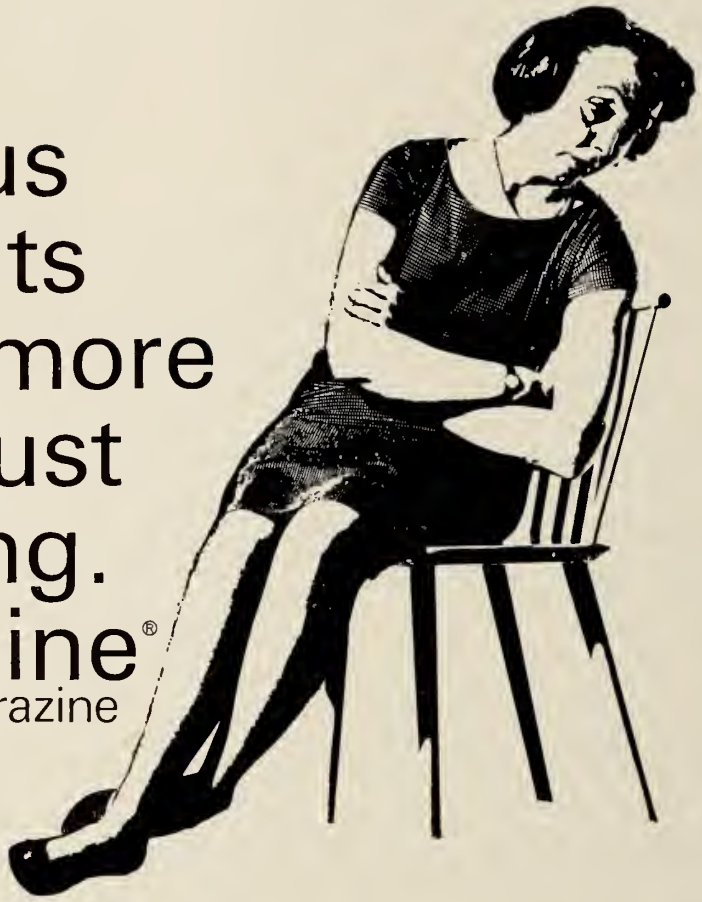
"QUICK, WATSON, THE SYNTHETIC QUININE!"

Any possible solution short of restoring normal supply of cinchona bark at reasonable prices seems to lie in three areas: The ability of the American pharmaceutical industry to develop new quinine and quinidine substitutes, success in developing low cost synthetic processing, or finding a new source possibly in this hemisphere, of new cultivated cinchona groves. A real challenge? Of course it is, but American drug makers have quite a reputation for achieving success in the face of near-impossible circumstances.—Rowland B. Kennedy, in *Journal of the Mississippi State Medical Association,* (6:458), December 1965.

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Contraindicated in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects,* usually dose related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems. Before prescribing, see SK&F product Prescribing Information.

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Scenes from the Annual Meeting of the Alabama Chapter, American College of Surgeons



New officers for the Alabama Chapter, American College of Surgeons are (left to right) Dr. Walker Reynolds, Anniston, Secretary-Treasurer; Dr. H. Gordon King, Tuscaloosa, President; and Dr. John M. Slaughter, Fairfield, President-Elect.



Dr. Leonard W. Fabian, Jackson, Mississippi, (left) speaker at the February 11-12, annual meeting of the Alabama Chapter, American College of Surgeons, is shown with Dr. J. Garber Galbraith and Dr. E. B. Glenn, both of Birmingham.



Dr. and Mrs. Richard Garrett, Montgomery, enjoying the pre-banquet get-together at Grand Hotel in Point Clear.



New first lady of Alabama Surgeons, a petite blonde, is shown with her husband, Dr. H. Gordon King.



After the meeting—Mrs. Richard Harris and Dr. Harris enjoy a relaxing meal in the dining room of the Grand Hotel.

AMA JOURNALS HAVE FOREIGN CIRCULATION OF NEARLY 40,000; PLAY MAJOR ROLE IN DISSEMINATING U. S. MEDICAL KNOWLEDGE

Until about a generation ago, the United States imported more medical knowledge than it exported.

In popular fancy, the American doctor was seen learning at the feet of a bearded European professor.

Today it's different. U. S. medical science and medical education have come of age and the United States is a net exporter of medical theory and technique. In medicine as in many other fields the world looks to the United States for leadership. Communist nations pay us the compliment of pirating from American medical publications.

American medical journals are an important means of disseminating up-to-the-minute medical knowledge throughout the world. They supplement the other major vehicle for exportation of medical knowledge: medical education. Thousand of foreign doctors have been educated in American medical schools and hospital postgraduate programs since the end of World War II and most of them probably stay in contact with American medicine through medical journals.

The most famous of American medical journals, the weekly Journal of the American Medical Association, is distributed to more than eight thousand paid foreign subscribers in 123 countries. The 10 monthly AMA specialty journals (dermatology, surgery, internal medicine, diseases of children, environmental health, general psychiatry, neurology, ophthalmology, otolaryngology, and pathology) go to more than 16 thousand paid foreign subscribers. Nearly two thousand copies of the AMA News, a newspaper of non-scientific medical news for physicians, goes to selected foreign subscribers, and Today's Health, the AMA medical publication for laymen, has a paid foreign circulation of nearly 10 thousand.

Thus, the publications of the AMA alone have a paid foreign circulation of nearly 40 thousand. (Total domestic and foreign Journal circulation is 212,504 per week; total specialty journal circulation is 222,307 per month.)

As the journal of American medicine, the Journal of the AMA (known to American doctors as JAMA) appeals to as broad a range of interests in foreign lands as it does in the United States.

Foreign practitioners value JAMA as a part of their continuing medical education. In its attention to drugs and drug therapy, for example, JAMA is invaluable to the foreign doctor who has access to American-made drugs.

In 1965, JAMA also published such papers as these:

—A listing and medical evaluation of all fertility control devices widely available in the United States. Published under the sponsorship of the AMA Committee on Human Reproduction, the paper represents the considered opinion of a number of medical authorities.

—An article on homosexuality and the physician's role in prevention and treatment.

—A multi-part series on current concepts in cancer detection and treatment.

—A monthly feature on bone fractures.

—Many articles on medical education, including considerations of medical education in developing nations.

Foreign subscribers to specialty journals found articles like these in 1965:

—A new treatment to combat infection in severe burns, based on the use of silver nitrate on burned areas. Developed at Washington University and hospitals in St. Louis,

the treatment was reported in the journal Archives of Surgery.

—A symposium on German measles (rubella), the usually mild viral disease that can cause congenital malformations in the unborn child of an infected mother-to-be. It was published as the entire October edition of the American Journal of Diseases of Children.

To a British physician on Harley Street, JAMA and the specialty journals may be necessary checkpoints in a week of "keeping up with the journals." British physicians, like American, probably read 10 to 20 medical publications regularly. To a physician practicing in Southeast Asia, though, a single copy of JAMA at the local hospital may be a most valued contact with current medical thought. Some underdeveloped nations receive only one or two copies of JAMA through paid subscriptions, and these often go to a hospital; but the AMA Department of International Health estimates that nearly every English-speaking doctor and medical technician having access to the "hospital copy" makes an attempt to read every issue. The estimate is made on the basis of conversations with foreign doctors visiting the U. S., and with U. S. physicians returning from service in underdeveloped nations.

Nearly every major medical school and medical library in the world also gets at least one copy of JAMA for teaching and reference. Information volunteered to the AMA Department of International Health by foreign physicians indicates that a single library copy of JAMA may go through the hands of 40 or more readers.

A number of Communist nations, including isolationist Albania, Bulgaria, the Soviet Union, and Mainland China, receive from one to a dozen copies of JAMA weekly. Most of the copies go to medical schools, where, according to the AMA Circulation and Records Department, they often are duplicated for wider distribution. Although the published material in JAMA is protected by copyright, the Soviet Union and some other Communist states do not recognize copyright regulations.

As an indication of the extent to which the Soviet Union duplicates JAMA, only six paid-subscription copies are sent to the USSR but nearly every Russian physician who visits the United States confides that he is a regular JAMA reader.

Hundreds of American medical missionaries in foreign lands receive JAMA and other AMA publications free of charge. The AMA furnishes the publications as a means of permitting these dedicated doctors to stay abreast of medical developments and remain in contact with main currents of American medicine, despite their isolation from medical centers. JAMA circulation to some countries—the Congo and New Guinea, for example—is all or nearly all of this nonpaid type.

Some examples of JAMA paid-subscription circulation throughout the world:

—1,135 copies go to Canada. More than 200 of these are to Montreal, and hundreds more to Toronto, Ottawa, and other major centers of Canadian population. In the vast northern areas of Canada a number of doctors are served by a hospital "single copy": one such example is the single copy of JAMA sent to Whitehorse General Hospital, Whitehorse, Yukon Territory. Paid-subscription circulation of all AMA publications in Canada is 12,045. (Canada has about 22,600 physicians, according to World Health Organization statistics.)

—The four JAMA copies going to Afghanistan are received by two U. S. Peace Corps physicians, a UNICEF Public Health Institute in the Ministry of Health, and an American medical team operating on funds from a private U. S. organization.

—The 10 foreign nations with highest JAMA circulation are Canada, 1,135; Italy, 777; Japan, 671; England, 346; India, 338; Holland, 318; Mexico, 298; France, 275; West Germany, 260; Sweden, 250.

AMA AFFIRMS STATEMENTS ON FEES FOR SERVICE

The American Medical Association House of Delegates, meeting in Philadelphia November 28-December 1, approved eight statements on medical service fees charged by physicians. These are applicable "irrespective of whether such fees are paid by the patient, or paid or reimbursed in whole or in part under Public Law 89-97, or any other third party plan," the House stated. Here are the eight statements:

"1. The intimate relationship between physician and patient is served best without the interposition of any third party carrier, whether in the area of diagnosis and treatment or the payment for these services.

"2. It is the patient's responsibility to deal with third party carriers in the area of financial assistance, provided that the physician is at all times mindful of his obligations to the patient under Section 1 of the Principles of Medical Ethics.

"3. The physician-patient relationship is served best when there is an advance understanding regarding the payment of fees and the physician bills the patient directly for services rendered. However, the physician is ethically free to choose in each case the manner in which he is to be compensated, based upon the exercise of his independent judgment.

"4. The American Medical Association does not approve of any program which may directly or indirectly promote the charging of excessive fees or which interferes with the physician's right to charge fees commensurate with the services he renders.

"5. The American Medical Association opposes any program of dictation, interference, or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97, or other third-party plans.

"6. It should be remembered that insurance does not create any new wealth. It merely assists in conservation. Insurance may conserve the ability of an insured person to fulfill his normal financial obligations. It does not enhance his ability to discharge added responsibilities if they are in the form of increased fees. To use insurance as an excuse to revise professional fees upward is but to contribute to the defeat of its purpose. If these indisputable and self-evident facts are not embraced by the entire membership of the profession, then it will have dealt irreparable harm to the whole movement. Also, any such failure might give impetus to whatever demand now exists for forcing rigid benefit schedules on the professional. (The foregoing is from a report of the Council on Medical Service to the House of Delegates at the Clinical Meeting in 1954.)

"7. The charging of an excessive fee is unethical and is contrary to Section 7 of the Principles of Medical Ethics. The physician's fee should be commensurate with the services rendered and the patient's ability to pay. (The foregoing is from a report of the Judicial Council which was approved by the House of Delegates at the Clinical Meeting in 1960.)

"8. It is not contrary to conscience for the physician to consider the patient's ability to pay if he fixes his particular fee within reasonable limits. In matters relating to fees, the physician should try, to the best of his ability, to insure justice to the patient and himself and respect for his profession. (The foregoing is from an opinion of the Judicial Council in 1958.)"



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Dosage: One or two tablets, one-half hour before bedtime.

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Contraindications: Patients sensitive to barbiturates. Use with caution in the presence of moderate to severe hepatic disease.

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Effective in a wide range of everyday infections —respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Warning — In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of discomfort.

Precautions and Side Effects — Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. Use of demethylchlortetracycline during tooth development (last trimester of pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs mostly during long-term use but has also been observed in short treatment courses. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment. Side reactions include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and dermatitis. If adverse reaction or idiosyncracy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg of demethylchlortetracycline HCl.

Tablets: film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

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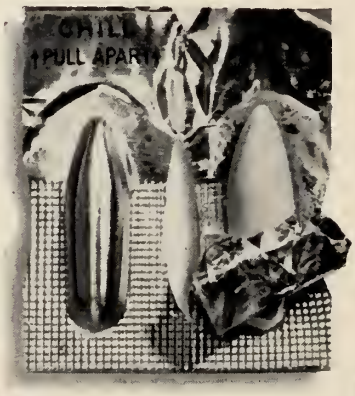
Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form...both are now available.

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COMPOSITION:
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INDICATIONS:
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Physicians Recommend Tuberculosis Tests

The American Academy of Pediatrics and the American College of Chest Physicians have recommended that all children between the ages of six and 12 months of age be tested for tuberculosis.

The tests should be given, if possible, before the child has been vaccinated against measles or smallpox.

The recommendations of the two organizations were made in a joint-committee statement appearing in the current issue of the AP'S *News Letter.*

The Committee emphasized that tuberculous infection in children is still prevalent, and that testing for tuberculosis should be "repeated annually up to four years of age and thereafter every two years, depending on the risk of exposure of the child and the prevalence of tuberculosis in the population group."

The Committee noted that early treatment of tuberculosis with the drug, isoniazid, has been especially effective in young children.

In an earlier statement, the two organizations urged their members and other groups of physicians including obstetricians, general practitioners, and health officers to "join in the nationwide endeavor to protect children against the hazards of tuberculosis."

The statement noted that children infected with tuberculosis should be "treated with well-known methods to prevent them from developing tuberculous complications during childhood."

The statement indicated that such testing and treatment would "speed up" the elimination of tuberculosis, and that "all necessary procedures are now available to accomplish this goal."

Tuberculosis annually infects approximately 20 million people throughout the world, resulting in death for some three million people each year.

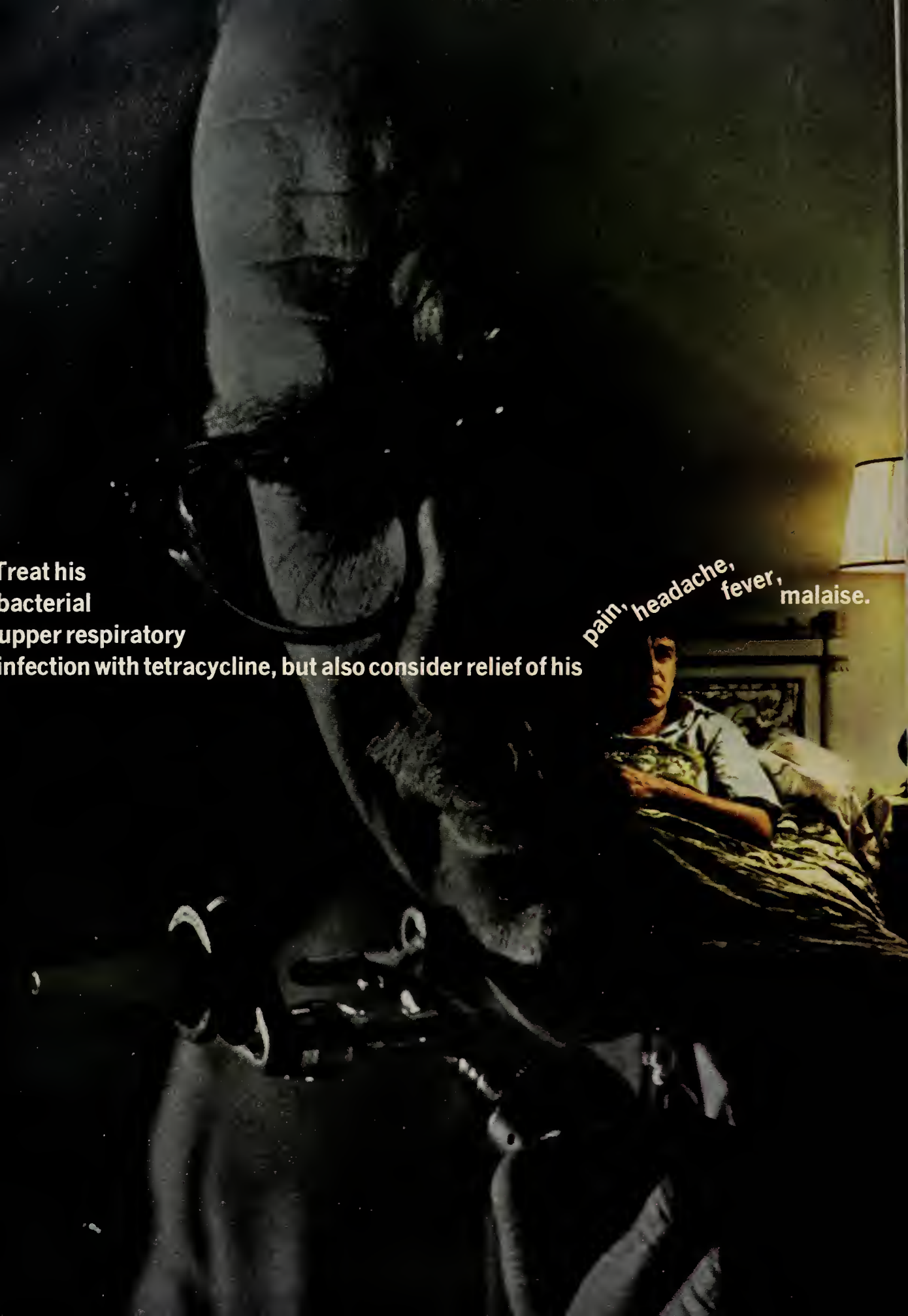
The American Academy of Pediatrics, with headquarters in Evanston, Ill., is the Pan-American association of physicians certified in the care of infants, children, and adolescents.

The Academy has more than 9,100 members in the U. S., Canada, and Latin America.

* * *

THE COST OF NO CANCER CURE

If any one group of people, whether it be industry or Government, ever started directing all the research, research would be dead. It may sound as if there is some duplication, but it is duplication of objective, rather than duplication of work. If, for example, three companies are working on the solution of the cancer problem, it is likely that each will be using a different approach to the solution. It is true that the research will cost three times as much, but there will be three times as many chances to solve the problem. . . . I'd rather pass on to the consumer the cost of the cancer cure than to pass on to the consumer the cost of no cancer cure.—Dr. Thomas F. Carney in broadcast over radio station WBBM, Chicago, December 7, 1965.


Treat his
bacterial
upper respiratory
infection with tetracycline, but also consider relief of his
pain, headache, fever, malaise.

Effectively combat bacterial infection and maintain relief of respiratory symptoms

Tetrex®-APC

with Bristamin®

(tetracycline phosphate complex with analgesics and antihistamine)

The advantages of Tetrex® (tetracycline phosphate complex). It contains the basic tetracycline which is less bound to serum protein than is demethylchlortetracycline[1]. (It puts a higher percentage of active antibiotic into the blood.) Its basic tetracycline is also better tolerated than oxy- or demethylchlortetracycline.[2,3] *Unlike demethylchlortetracycline,[4] no cases of photodynamic skin reaction have been reported with Tetrex (tetracycline phosphate complex).*

with the benefits of APC and Bristamin (phenyltoloxamine citrate). Traditional APC provides predictable relief of pain, fever and malaise in acute respiratory infections, while the phenyltoloxamine citrate—notable for its effective histamine-blocking action with minimal drowsiness—adds relief of watering eyes, rhinorrhea, congestion and "tight" chest symptoms.

References: 1. Roberts, C.E., Jr.; Perry, D.M.; Kuharic, H.A., and Kirby, W.M.M.: Arch. Int. Med. *107*:204 (Feb.) 1961. 2. Dowling, H.F.; Lepper, M.H., and Jackson, G.G.: Clin. Pharmacol. & Therap. 3:564 (Sept.-Oct.) 1962. 3. Editorial: Antibiotics & Chemother. *11*:427 (July) 1961. 4. Baer, R.L., and Harber, L.C.: JAMA *192*:989 (June 14) 1965.

BRISTOL

BRISTOL LABORATORIES / Division of Bristol-Myers Co., Syracuse, New York

BRISTOL THERAPEUTIC SUMMARY. For complete information, consult Official Package Circular. *Indications.* Upper respiratory infections due to sensitive bacteria where concomitant symptomatic relief of fever, malaise and congestion is desired. *Contraindication:* A past history of hypersensitivity to one or more components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if discomfort occurs. No cases of photosensitivity have been reported with Tetrex (tetracycline phosphate complex). With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Antihistamines may cause drowsiness and patients should not perform tasks requiring mental alertness while taking this agent. Bacterial or mycotic superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for three months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis and allergic reactions may occur. *Usual Adult Dose:* Two capsules *q.i.d.* Continue therapy for at least 10 days in beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.

skin

The cancer with the highest incidence: skin. The cancer with the highest mortality rate: lung. Both, ironically, the most preventable of all cancers.

Lung cancer kills some 47,000 Americans every year. Estimates are that more than 75% of lung cancers are caused by cigarette smoking... a preventable habit.

About 80,000 Americans develop skin cancer each year. Since its principal cause is excessive exposure to the sun, preventive measures are clear.

Basal cell and squamous cell carcinoma, commonest forms of skin cancer, are easily cured in their early stages. The high incidence of skin cancer, the suffering, disability and disfigurement which too often accompany it, make it a challenging problem.

In its program of bringing vital facts about cancer to the public, the Society has two new films, both available for showing through any ACS Unit. WHO, ME? dramatizes the hazards of cigarette smoking. SENSE IN THE SUN urges both sun workers and sun worshippers to exercise caution. Like all Society films, their object is to save lives and diminish suffering from cancer by giving forceful expression to many of the facts about cancer with which you, doctor, guide your patients.

american cancer society®

lung?

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Facts and Fancies About Mental Illness

Facts and fancies about mental illness, from witchcraft practices to contemporary community mental health centers, are presented in an illustrated booklet recently issued by the National Institute of Mental Health, Public Health Service, U. S. Department of Health, Education, and Welfare.

The 20-page publication, "Mental Illness and Its Treatment—Past and Present," traces the historical development of man's recognition of and reaction to the problems of defective behavior among members of his social community.

Early treatment of mental illness was based upon the belief that the disturbed individual was beset by evil spirits. Thus the most popular cures included trephining—surgical attempts to open pathways from the brain to allow the spirit to escape—and exorcistic rites.

The Greeks and Romans applied more scientific thinking to the problem and categorized various types of mental disorders on a fairly sophisticated level. As in the case of technical achievements, however, these medical studies were lost during the Middle Ages. Fifteenth Century Europeans reverted to superstitious beliefs and demonology.

In the United States the Pennsylvania Hospital in Philadelphia was the first to open its doors to the mentally ill, in 1756. In 1773 a hospital exclusively intended for the treatment of mental illness was established in Williamsburg, Virginia.

The first steps toward public understanding of mental illness came as health professionals themselves attained more knowledge of the intricacies of the mind. Freud's theories not only generated new ideas among his colleagues, but enlarged the perspective of the general populace.

Unfortunately, the common attitude about the mentally ill continued to be one of fear and repulsion. Dorothea Dix's campaign in the 1800's resulted in some improvements in housing facilities, but the "insane" had little prospect of recovery after they had been put away.

One notable exception to this pattern was publicized by Clifford W. Beers, in a book titled *A Mind That Found Itself*. Having spent three years as a patient himself, Beers was well qualified to describe the harsh treatment and lack of therapy which prevailed in most mental institutions. After writing the book he formed the National Committee for Mental Hygiene and spent the rest of his life developing programs for the treatment of mental illness.

By the late 1940's the mental health movement was firmly established in the United States. Federal legislation provided financial assistance to the States for mental health programs and also led to the establishment of the National Institute of Mental Health in 1949.

The Community Mental Health Centers Act of 1963 marks the latest advancement in the field of mental health. This Act and a 1965 amendment provide funds for the construction and staffing of facilities in local areas so that the mental patient can have access to the best possible treatment and still remain near his home.

Single copies of booklet, Public Health Service Publication No. 1345, can be obtained free of charge from the Public Health Service, Washington, D. C. 20201. Multiple copies are available at 20 cents each from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402, with quantity rates available for orders exceeding 100 copies.

From the U. S. Department of Health, Education, and Welfare, Public Health Service, National Institutes of Health, National Institute of Mental Health; Bethesda, Maryland 20014.



more complete relief for the "dyspeptic"

DACTILASE®

Dactilase provides comprehensive therapy for a wide range of digestive disorders. Its antispasmodic and anesthetic actions rapidly relieve pain and spasm. Dactilase decreases hypermotility without inducing stasis. In addition, it supplies digestive enzymes to help reduce bloating, belching and flatulence. Dactilase does not interfere with normal digestive secretions. Very often it can be a most useful answer to the dyspeptic's needs.

DACTILASE: Each tablet contains: Dactil® (piperidolate hydrochloride), 50 mg.; Standardized cellulolytic* enzyme, 2 mg.; Standardized amylolytic enzyme, 15 mg.; Standardized proteolytic enzyme, 10 mg.; Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established. **As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.

Side Effects and Contraindications: DACTILASE is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

LAKESIDE LABORATORIES, INC.
Milwaukee, Wisconsin 53201



An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

Miltown® (meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

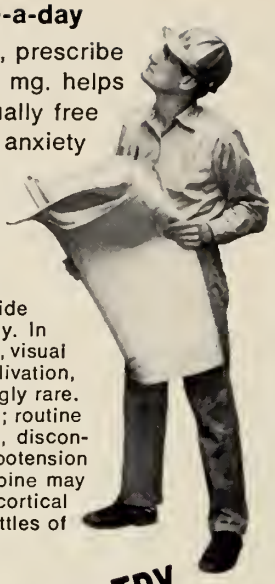
Before prescribing, consult package circular.

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Blueprint for dealing with tension due to stress — Prolixin — once-a-day

For the patient who must be on the job mentally as well as physically, prescribe Prolixin. The prolonged tranquilizing action of as little as one or two mg. helps him cope with tension all day long. Markedly low in toxicity and virtually free from usual sedative effects, Prolixin is effective in controlling both anxiety associated with somatic disorders and anxiety due to environmental or emotional stress. Patient acceptance is good — because Prolixin is low in cost, low in dosage and low in sedative activity. Prescribe Prolixin.



Side Effects, Precautions, Contraindications: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photosensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders. **Available:** 1 mg. tablets. Bottles of 50 and 500. For full information, see Product Brief.

WHEN TRANQUILIZATION WITHOUT SEDATION IS DESIRABLE, TRY

PROLIXIN®

THE SQUIBB TRANQUILIZER

SQUIBB FLUPHENAZINE HYDROCHLORIDE

SQUIBB Squibb Quality — the Priceless Ingredient



FOR A CLEAN START IN VAGINITIS THERAPY

superior cleansing action ■ STOMASEPTINE is "a highly effective mucolytic cleansing agent"[1] that removes debris and flushes out secretions more thoroughly than acid douches.[1] Alkaline STOMASEPTINE "dissolves and removes leukorrheal secretions"[1]—whereas acid douches tend to "coagulate or set the vaginal contents."[2] Low surface tension and release of nascent oxygen contribute to deep penetration and cleansing of rugae.

enhances specific therapy ■ Thorough cleansing of the vaginal vault with STOMASEPTINE enhances the effectiveness of specific vaginitis therapy, ensures maximum contact of topical medication with mucosa.

excellent patient acceptance ■ Anti-pruritic and soothing, pleasantly scented—patients feel "fresh and clean."

1. Weese, H.: Personal Communication, Sept. 25, 1964. 2. Glynn, R.: Obst. & Gynec. 20:369, 1962.

Contains: sodium perborate, sodium bicarbonate, sodium chloride, sodium borate, menthol, thymol, eucalyptol, methyl salicylate and aromatics—
6 oz. and 15 oz. jars; cartons of 12 10-gm. packets

Literature and professional supply on request.

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MEDICAL ECONOMICS ANNOUNCES WRITING AWARD PROGRAM

The National Association of Blue Shield Plans announced that it would sponsor the 1966 Norman A. Welch, M. D., Memorial Award Program.

The award will be made to the author of the most scholarly and meritorious contribution to the literature of medical economics between July 1, 1965 and June 30, 1966. The contribution can be an article or series of articles, a book, or a published or delivered speech.

The annual award was established by the National Association of Blue Shield Plans in 1965 to honor the memory of Dr. Welch, long active in Blue Shield and President of the American Medical Association when he died in September, 1964.

The award consists of a medallion of solid gold emblazoned with a bust of Dr. Welch and $1,000 contributed in the author's name to the Norman A. Welch, M. D., Memorial Fund of the American Medical Association Education and Research Foundation.

Winner of the 1965 award was Herbert E. Klarman, Ph. D., professor of Public Health Administration at Johns Hopkins University, for his book *Economics of Health.*

The award winner will be selected by a three-man committee comprised of representatives of the American Medical Association, the American Medical Writers' Association, and the board of directors of the National Association of Blue Shield Plans.

Literature to be judged will be compiled by the library of the National Association of Blue Shield Plans. Authors may submit entries by sending them to: Library, National Association of Blue Shield Plans, 425 North Michigan Avenue, Chicago, Illinois 60611. Deadline for entries is September 1.

Announcement of the winner and presentation of the award will be made at the 1966 Annual Program Conference of the National Association of Blue Shield Plans in Chicago, October 10.

ANIMALS TO PROTECT BABIES

The problem of predictability of toxicity of drugs continues to be subject to considerable scrutiny by pharmaceutical research scientists. Many thousands such scientists are at work independently or in consultation with the pharmaceutical industry, or are employed under government or private auspices. Testing of drugs before they are marketed is extremely thorough. The Pharmaceutical Manufacturers' Association states that its members made use of nearly nine million animals in 1961, including 5.7 million mice, 2.2 million rats, 739,000 chickens, 107,000 guinea pigs, 98,000 rabbits, 36,000 dogs and 18,000 cats, as well as thousands of other birds and animals. The possibility of drug effect upon the unborn child has not been neglected, although the recent attention this has received in the public press has caused it to be considered very gravely by all concerned. Editorial in *Chicago Medicine,* (68:873), October 2, 1965.

* * *

THE DRIVING DRINKER

THE DRIVING DRINKER is the primary problem—rather than the drinking driver, according to a two-year study in San Francisco. Dr. Julian A. Waller of the California Department of Public Health reported a study showing that a majority of drinking drivers in accidents or apprehended for drunken driving were problem drinkers rather than social drinkers. Another study showed that 38 per cent of a group of drunken drivers had a record of prior offenses while under the influence of alcohol. Cirrhosis of the liver or fatty livers were found in almost two-thirds of those drivers who died within six hours of the accident and who had high blood levels of alcohol. In contrast, only 15 per cent of the alcohol-free fatalities had similar abnormal findings associated with the liver. Although alcoholism is a major factor in driving accidents, Dr. Waller cautioned that learning to drive and experimenting with drinking makes a hazardous combination. This was underscored by the comparatively low blood alcohol values found in drivers under age 25 who died in accidents.—*Modern Med.*, Oct. 25, p. 64.

The discomforts of

DIARRHEA
MUCOUS COLITIS
DIVERTICULITIS
SPASTIC URETERITIS
BLADDER SPASM

. . . are relieved by direct musculotropic action with

Trocinate®

BRAND THIPHENAMIL HCl

Available in 100 milligram pink sugar-coated tablets.

The high therapeutic index permits dosage sufficient to relieve spasm promptly. The usual initial dose is 4 tablets. Maintenance dosage is usually one or two tablets 4 times a day.

Trocinate *BRAND* THIPHENAMIL HCl

BETA-DIETHYLAMINOETHYL DIPHENYLTHIOACETATE HYDROCHLORIDE

. . . directly relaxes smooth muscle spasm
. . . combats hypermotility
. . . non-mydriatic – may be used in glaucoma

Trocinate (Thiphenamil HCl) has been found in three clinical studies, (J. Mo. Med. Assoc., 48:685-6; Med. Rec. & Annals, 43:1104-6; J. Urol., 73:487-93), to be effective and to be free of side-effects. Fifteen years of wide clinical usage has affirmed the safety and effectiveness of Trocinate.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

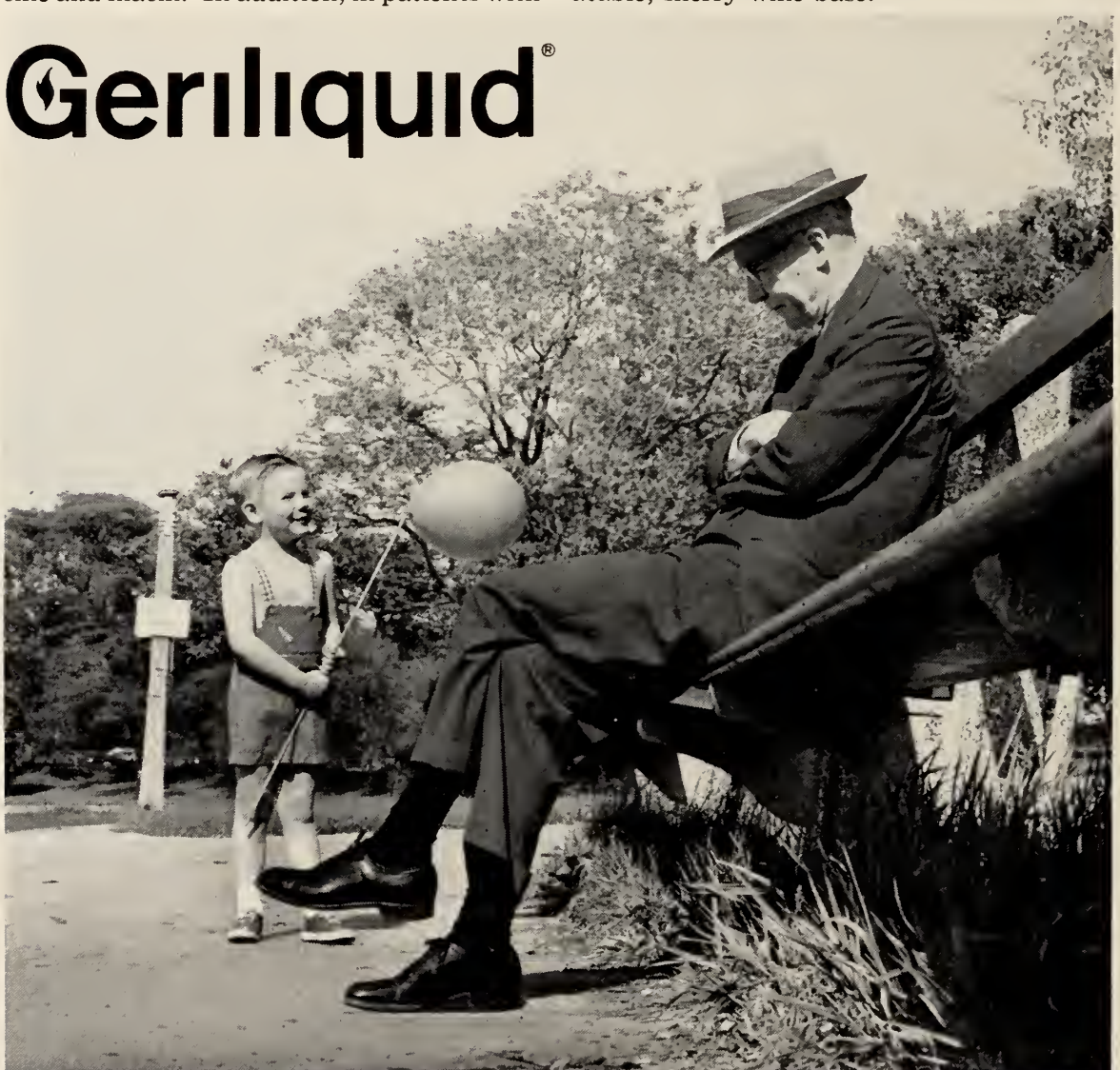
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provide rapid, sustained vasodilation for warmth and relief of pain, dizziness and faintness in patients with impaired peripheral circulation

GERILIQUID warms cold hands and feet through the thermogenic action of glycine and through sustained vasodilation by glycine and niacin. In addition, in patients with impaired peripheral circulation, GERILIQUID increases the ability to walk farther with less pain. Patients particularly like the palatable, sherry wine base.

Geriliquid®



IN BRIEF: Composition: Each 5 ml. contains: niacin 75 mg. and aminoacetic acid (glycine) 750 mg. in a palatable sherry wine base; alcohol 5%.
Side Effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is concomitant administration of a coronary vasodilator.
Administration and Dosage: One or two teaspoonfuls 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation.
Supplied: Bottles of 8 oz. and 16 oz.

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

TEACHERS OF FAMILY MEDICAL PRACTICE TO TRAIN UNDER NEW GRANT TO K. U.

Two fellowships to train teachers of family medical practice have been established at the University of Kansas School of Medicine, under a grant from the American Academy of General Practice Foundation.

The fellowships were announced today by Dr. C. Arden Miller, dean of the Kansas school. The grant making the positions and program possible is for $73,600 and covers a period of two years. The AAGP Foundation, whose headquarters are in Kansas City, was established to receive and administer funds to improve the teaching and practice of family medicine. Its president is Dr. John Walsh, Sacramento, Calif.

In his announcement, Dr. Miller said the fellowships would be used "to support and train two young physicians to become qualified as teachers in family practice . . . with particular emphasis on faculty organization and administration."

A problem in increasing the number of family doctors in the U. S. has been a lack of medical school emphasis on family practice as a specific segment of medicine. This has been due partly to the specialist makeup of most faculties and partly to the lack of family doctors willing to teach.

Needed is a corps of family physician teachers trained in academic matters who will spend full-time as members of medical school faculties. The corps then would help orient and stimulate practicing family doctors to serve as parttime teachers. The K. U. fellowships are viewed as a beginning of this teaching corps.

Recipients of the fellowships will be young family doctors who have had sufficient graduate training (beyond internship) and at least several years in private practice. Each, according to Dr. Miller, will follow a planned program of both instruction and teaching, participating in the major clinical departments, the outpatient departments of the medical center, and in the medical school's Home Care Program. They will attend faculty meetings, have regular faculty committee duties, and assist in planning and conducting postgraduate medical courses.

Dr. Jesse D. Rising will serve as project director and Drs. Jack Walker and Charles Lewis as co-directors. All are regular faculty members.

Mac F. Cahal, secretary-treasurer of the AAGP Foundation, described the fellowship as "an all-important seeding operation for what is expected to become a basic and vital segment of medical education in the next several decades."

AN AVOIDABLE HAZARD

IF YOU DRINK, DON'T DRIVE is a slogan that could well be updated to read: If you drink, don't fly your own plane. Drinking has been identified as a contributing factor in more than 30 per cent of fatal aircraft accidents in the Federal Aviation Agency's southwest region, reports Dr. Harry L. Gibbons. Postmortem studies in 77 per cent of the 86 regional crashes occurring last year revealed that alcohol was a factor in 26. More than half the alcohol-related accidents involved private planes, and in 41 per cent, the pilots had 1,000 hours or more flying time. Pilots are warned that flying after drinking "is an avoidable hazard."—*Med. World News,* Oct. 22, p. 35.

* * *

AN ESTIMATED ONE IN FOUR DIABETICS has a water-soluble substance in his blood plasma that inhibits ABO blood group antibody reactivity, a Texas-based study has found. The substance, not yet identified, appears unrelated to sex, race or the drug used to control the disease. Unless strong immune antibody is used in blood group test reagents, errors in blood typing of diabetics may occur, reports L. Ruth Guy, Ph. D.—*J. A. M. A.,* Oct. 18, p. 36.

American College of Physicians Announces Associates and Fellowships

As Governor of the American College of Physicians for Alabama, I am pleased to announce that the physicians on the attached list were elected to Associateship and advancement to Fellowship in the American College of Physicians as the result of action taken by the Credentials Committee of the College which met in Philadelphia, Pa., on November 10, 1965.

Walter B. Frommeyer, Jr., M. D.
Governor for Alabama,
American College of Physicians

ASSOCIATES ELECTED

November 10, 1965

Edwards, John A., Jr. — Anniston, Alabama

Farmer, Thomas A., Jr. (Asst. Prof.)
University of Alabama Medical Center — Birmingham, Alabama

Foster, Glenn L. (Asst. Prof.)
University of Alabama Medical Center — Birmingham, Alabama

Issos, Demetrius N. (re-in) — Birmingham, Alabama

Russell, Richard O., Jr. (Asst. Prof.)
University of Alabama Medical Center — Birmingham, Alabama

Jones, Samuel H., Jr. — Dothan, Alabama

Chandler, Adrain A. — East Gadsden, Alabama

Ennis, Arthur L. — Gadsden, Alabama

Simpson, William H. — Gadsden, Alabama

Parks, James M. — Montgomery, Alabama

Putzell, Charles L., Jr. (re-in) — Selma, Alabama

Carmichael, Archie H., III — Sheffield, Alabama

Holt, John H. (Asst. Prof.)
University of Alabama Medical Center — Birmingham, Alabama

FELLOWS ELECTED

Branscomb, Ben V. (Assoc. Prof.)
University of Alabama Medical Center — Birmingham, Alabama

Eagan, John T. — Birmingham, Alabama

Fang, Harry C. H. (Assoc. Prof.)
University of Alabama Medical Center — Birmingham, Alabama

Montgomery, James T. — Birmingham, Alabama

Barrett, James C. — Mobile, Alabama

White, H. Aubrey, Jr. — Mobile, Alabama

* * *

HAVE YOU HEARD THIS TRUE STORY?

There is a meaty kernel of truth in the story that pharmaceutical companies have to tell to doctors. Some of these companies have developed splendid laboratories for research. They spend millions of dollars a year looking for new drugs. And every year they are finding new drugs, some of which lower mortality rates, shorten illness, prevent disease or make life for the chronically ill more tolerable. The more ethical companies search diligently for the truth about the effects of their drugs and tell doctors plainly what they have found.—Harry F. Dowling, M. D. in *Emory University Quarterly*, (21:98-99), Summer 1965.

WHEN MOTHER'S IRON ISN'T UP TO MOTHERHOOD

IN BRIEF: **ACTIONS AND USES:** A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency anemia may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion *as a source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. of elemental iron in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache, and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only, it is contraindicated in other anemias.

CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

in iron deficiency anemia for rapid and predictable replacement of iron reserves

imferon®

(iron dextran injection)



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SALMONELLA CARRIERS PRESENT A FORMIDABLE FIFTH COLUMN.

Furoxone exerts "outstanding activity against Salmonella sp." and "has enhanced the physicians' armamentarium in that it now affords a relatively effective, safe bactericidal agent, which may be used to treat the active disease as well as the carrier state".[2]

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Do not give to infants under one month of age.

Composition: Furoxone Liquid contains, per 15 cc. tablespoonful, furazolidone 50 mg., pectin 225 mg., and kaolin 3.0 Gm. Furoxone Tablets each contain 100 mg. of furazolidone.

References: 1. Editorial: J.A.M.A. *189*:691 (Aug. 31) 1964. 2. Foertsch, J. H.: J. Oklahoma Med. Assn. *57*:449 (Oct.) 1964. 3. Paul, H. E., and Paul, M. F.: The Nitrofurans—Chemotherapeutic Properties, in Schnitzer, R. J., and Hawking, F. (Eds.) Experimental Chemotherapy, Vol. 2, New York, Academic Press, 1964.

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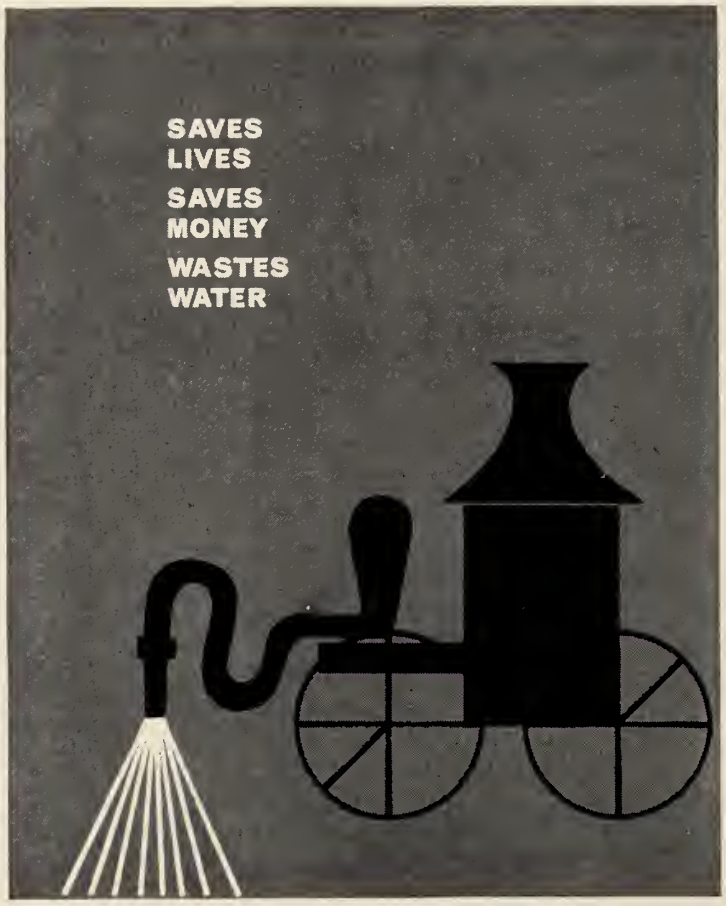
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Tenth Congress of the Pan-Pacific Surgical Association

PART I—September 20-28, 1966

Honolulu, Hawaii

* * *

Second Mobile Educational Seminar

PART II—September 28-October 10, 1966

Japan and Hong Kong

* * *

PART III—September 28-November 1, 1966

Japan, Hong Kong, The Philippines, Thailand, India, Singapore, Australia and New Zealand

The Board of Trustees of the Pan-Pacific Surgical Association announces the dates of the Tenth Congress in Honolulu and the Second Mobile Educational Seminars which travels to countries bordering the Pacific basin.

Part I, the Honolulu portion of the Congress, will convene at the Princess Kaiulani Hotel on September 20, 1966, and continue through September 28.

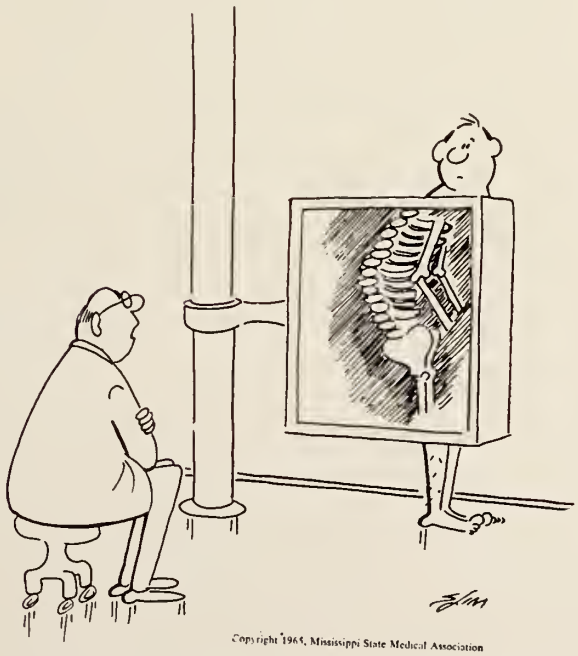
Part II and III will depart Hawaii on September 28 and travel to Japan and Hong Kong with Part II returning to San Francisco on October 10, in time for the opening of the American College of Surgeons, and Part III continuing on to the Philippines, Thailand, India, Singapore, Australia and New Zealand, returning to Hawaii on November 1, 1966.

The Tenth Congress offers an extensive scientific program presented by more than 450 leading surgeons from the United States and 22 other countries in 12 different specialties: Colon and Anorectal Surgery, General Surgery, Neurosurgery, Obstetrics and Gynecology, Ophthalmology, Otolaryngology, Orthopedics, Plastic Surgery, Thoracic-Cardiovascular Surgery, Urology, Anesthesiology and Radiology. All physicians and surgeons are invited to attend these meetings.

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For further information, please write:

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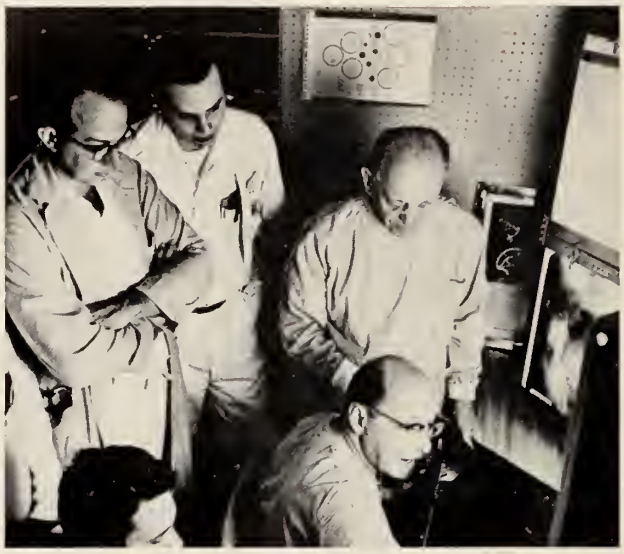


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Aquatic Rescue of Injured Personnel

Colonel Louis C. Kossuth, MC, USAF*

Drowning is only one of the hazards faced by individuals injured in aquatic accidents. The lack of proper handling of the injured may contribute to both the degree and duration of disability, and in certain injuries directly to an unfortunate outcome. Proper rescue techniques are essential to ultimate recovery.

The great increase in boating and aquatic sports in recent years has markedly increased the exposure of the public to aquatic injury. Although drowning is a major cause of accidental death, there has been a marked increase in many other types of injuries associated with aquatic activities. The use of life belts of various types has had a beneficial effect in the prevention of drowning in skiing mishaps, boat collisions, fishing misadventures and similar activities, but the principles of rescue of those injured in aquatic accidents have not been well defined.

In any aquatic accident first efforts must be to prevent drowning. The American Red Cross Life Saving and Water Safety Manual[1] thoroughly discusses getting to the victim, finding the victim, and other problems incident to the immediate aspects of rescue. Once the victim has been reached, the first task of the rescuer is an estimate of the situation: "Is this a simple rescue, or has the victim suffered injury in addition to submersion?"

If the victim is not breathing, regardless of whether this is due to disease, injury or submersion, artificial respiration should be started at the earliest possible moment. Swann[2] in an excellent investigation into the problems of resuscitation in drowning states "In spite of his apparent low requirement for O_2, the situation during semidrowning in man still seems to us cause for considerable pessimism. We shall develop the following thesis: it is known that when the lungs are flooded with pulmonary edema fluid, considerable respiratory effort is required to inspire and expire an adequate tidal volume. In semidrowning, both flooding of the lungs with water and edema occur. From what is known of the adequacy of artificial respiration, it appears likely to us that all methods involving manipulation of the chest will usually fail in semidrowning, because none can effectively overcome the effects of low compliance produced by aspirated water and edema fluid. Only the methods of ex-

*Commander, USAF Medical Service School (ATC), Gunter AFB, Alabama.

The views expressed herein are those of the author and do not necessarily reflect the views of the U. S. Air Force or the Department of Defense.

pired air breathing, e.g., mouth-to-mouth insufflation, can probably succeed."

Mouth-to-mouth insufflation is the method of choice. Gordon[3] illustrates mouth-to-mouth resuscitation while treading water, but the rescuer was a well-trained exceptionally fit lifeguard. British authorities[4] are more conservative and recommend that ventilation of the lungs begin as soon as the rescuer gets his feet on the bottom and that it be continued while wading ashore with the casualty. When to initiate mouth-to-mouth resuscitation must be an individual decision in each case. A strong swimmer may be able to tread water and accomplish effective resuscitation. A weaker swimmer attempting a rescue might need some type of flotation assistance. The important point is that MOUTH-TO-MOUTH RESUSCITATION BE INITIATED AT THE EARLIEST POSSIBLE MOMENT.

The injuries of concern to the rescuer are fractures, dislocations and hemorrhage. Today's high powered boat motors not only propel the boat with high velocity (and consequent increase of impact forces on collision) but the propeller blades can inflict extremely serious lacerations or compound fractures. Serious hemorrhage is a life threatening injury that must be treated second only to the establishment of respiration. The rescuer should fabricate a tourniquet from his own or the victim's clothing and immediately attempt to control bleeding.

The determination of other injury in an aquatic accident may be difficult. The simplest and best method is to ask the victim: Are you hurt? An affirmative reply indicates that special care must be taken in further rescue efforts. A primary objective in the treatment of trauma is to place the affected part at rest, and allow normal healing processes to restore the continuity of the affected tissue. Tugging, twisting or other stresses on the injured area increase the area of injury and will slow the normal healing process. Therefore, the injured victim in water must be handled with gentleness, and the rescue accomplished with a minimum of bending, twisting or placing other strains on the injury. The natural buoyancy of the human body assists the rescuer and allows the rescuer to move the victim with a minimum of stress to the affected parts. But this occurs only if the rescuer carefully determines what is to be done and then guides his actions to minimize stress to the injured parts.

The three steps of rescue all carry threats to the injured victim unless they are performed with gentleness and deliberately planned to avoid further injury to the victim. These three steps are the provision of flotation to the victim, movement of the victim to a boat, shore or dock, and removal of the victim from the water. Each of these steps requires movement of the victim but the last step is the most critical one. As the victim is taken from the water the buoyant effect is lost and increasingly greater strains are placed upon the victim.

The first step of provision of flotation is assisted by the normal buoyancy of the human body. Thus the provision of a minimum of assistance to an injured victim will usually provide adequate buoyancy to remain afloat until a boat can approach. Any available flotation gear can be used. Reassurance of the victim is necessary and he must be instructed just to lie quietly in the water, and particularly advised not to move the injured parts or struggle to keep afloat. Demostration by the rescuer that gentle support beneath the shoulders keeps the victim afloat adds to this reassurance. The most important aspect is the need to quiet the victim and provide as minimum movement as possible to the injured parts.

The succor established in the first step of rescue must be continued during the second step, the movement of the victim to a boat or shore. A surf board is an excellent item[5] for this purpose, but a plank, a life preserver, or any piece of flotation gear can be used. If it is necessary to swim ashore with the victim, the cross chest carry is recommended unless the victim has suffered a neck injury.

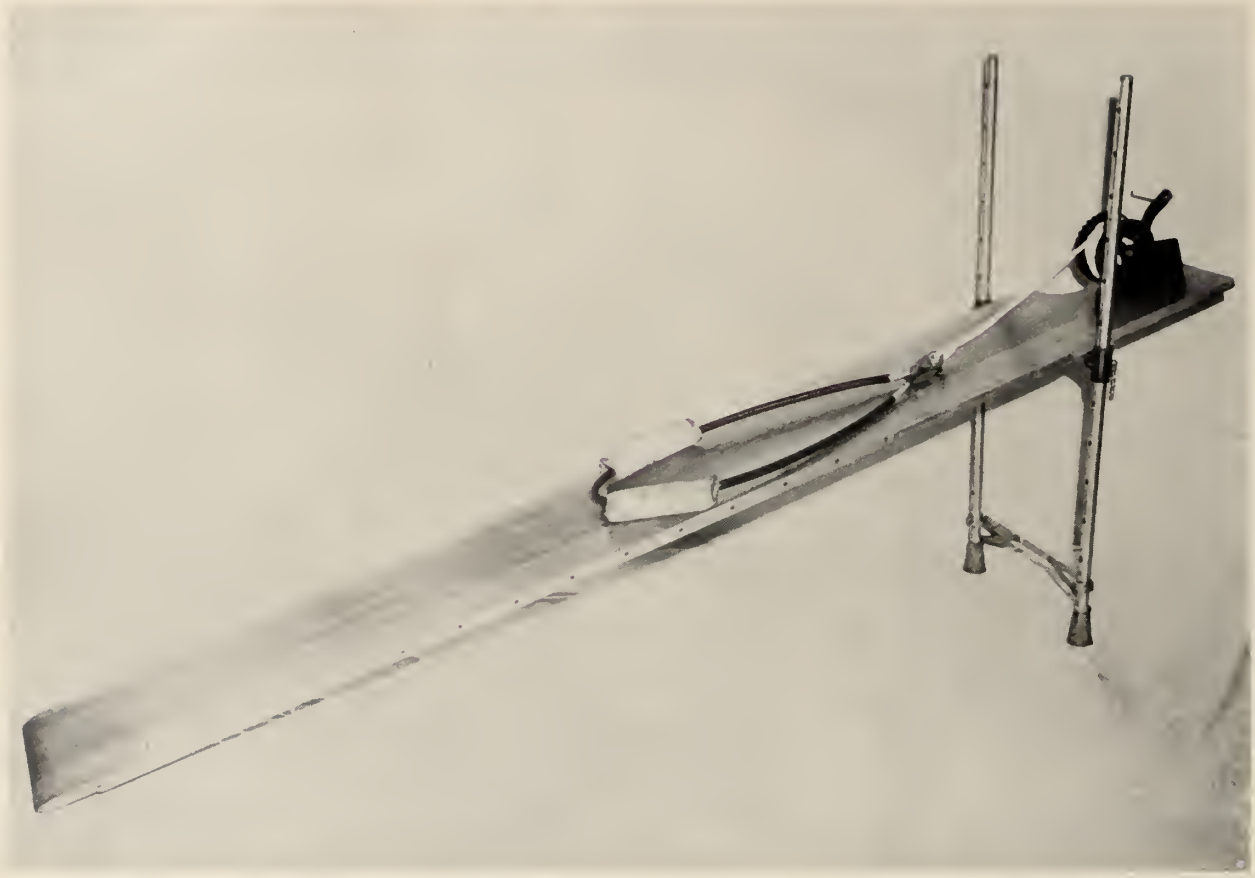


FIGURE 1. THE MSS WINCH BOARD. Note the strip metal reinforcement that provides rigidity to the board. By the use of pins inserted in the holes of the legs the board may be adjusted to varying heights. An ordinary boat winch is used to supply traction.

In this latter case, merely keep the victim afloat until a board, litter or other head to foot flotation and splint support can be provided.

The major problem comes however with the third step in attempting to remove the victim from the water. The U. S. Navy First Aid Manual[6] states "A seriously injured person should never, except in extreme emergency, be hauled out of the water by means of a rope or life line. Special methods must be devised which will provide proper support for the victim, keep him in a horizontal position, and protect him from any kind of jerking, bending, or twisting motion. The Stokes stretcher can often be used to rescue an injured person. The stretcher is lowered into the water, and the victim is floated into position over it. Men on the deck of the ship can then bring the stretcher up by means of handlines. Life preservers, balsa wood, unicellular material, or other flotation gear can be used if it is necessary to keep the stretcher afloat." This may be equally effective on a high dock, or the high vertical wall of a reservoir or a canyon. If the injured victim is brought to shore, a stretcher should be slid beneath him and then the victim carried from the water.

The USAF Medical Service School has developed a device for bringing injured into a boat or onto a low deck (Figure 1). This is a highly waxed board ten inches wide and seven feet long. At one end is a winch and rope which ends in a detachable loop. The loop contains two foam rubber axillary pads that can be adjusted to the patient, and the entire loop is padded with a garden hose. This provides for patient comfort when tension is applied. To use the MSS Winch



FIGURE 2. Over the side rescue is tricky. The operator must carefully watch the center of gravity of the boat to prevent capsizing. The operator MUST remain seated on the far side of the boat.

Board the loop is threaded through the axillae, the victim is aligned with the board and the victim slowly and gently winched onto the board.

Figures 2, 3 and 4 illustrate bringing a victim over the side of a boat. The MSS Winch Board operator sits on the far gunwale and winds the victim onto the board. As the victim is winched onto the board, the buoyant effect of the water is lost. As this is occurring the operator pulls back on the legs of the MSS Winch Board, which action slides



FIGURE 3. As the operator pulls the winch board (and victim) into the boat the angle of the board is reduced assisting in the rescue.



FIGURE 4. After the center of gravity of the victim has passed into the boat it is easy to rotate the victim aboard.

the board further into the boat until the center of gravity of the victim is inside the boat. At this point the rescuer in the water assists the operator in swinging the winch board inboard. Once aboard, the victim may be splinted, wounds treated, or the boat may proceed to shore for definitive medical care.

Figures 5, 6 and 7 illustrate bringing a victim on the stern of a boat. This is the preferred method, but with outboard motors so common the stern approach is often not available. This approach has safety features in that the boat is more stable, and as the MSS Winch Board operator pulls the board inward by lowering the legs, the center of gravity is reached without crowding the operator. Although the wet victim ordinarily slides readily on the board, some fabrics tend to stick. In such cases, a little detergent poured on the board quickly reestablishes a slippery surface.

Although it is not illustrated, a reverse technique could be used if the victim has shoulder girdle or chest injuries. In this case, the loop is placed around the ankles and the patient brought onto the MSS Winch Board feet first. The rescuer in the water in this instance must provide flotation assistance as the victim is drawn up on the board.

Once the victim has been removed from the water, usual first aid procedures are applied:



FIGURE 5. The principles of over the stern rescue are similar to over the side but a far safer procedure.



FIGURE 6. The operator reels in the winch rope at the same time he is pulling the board into the boat.

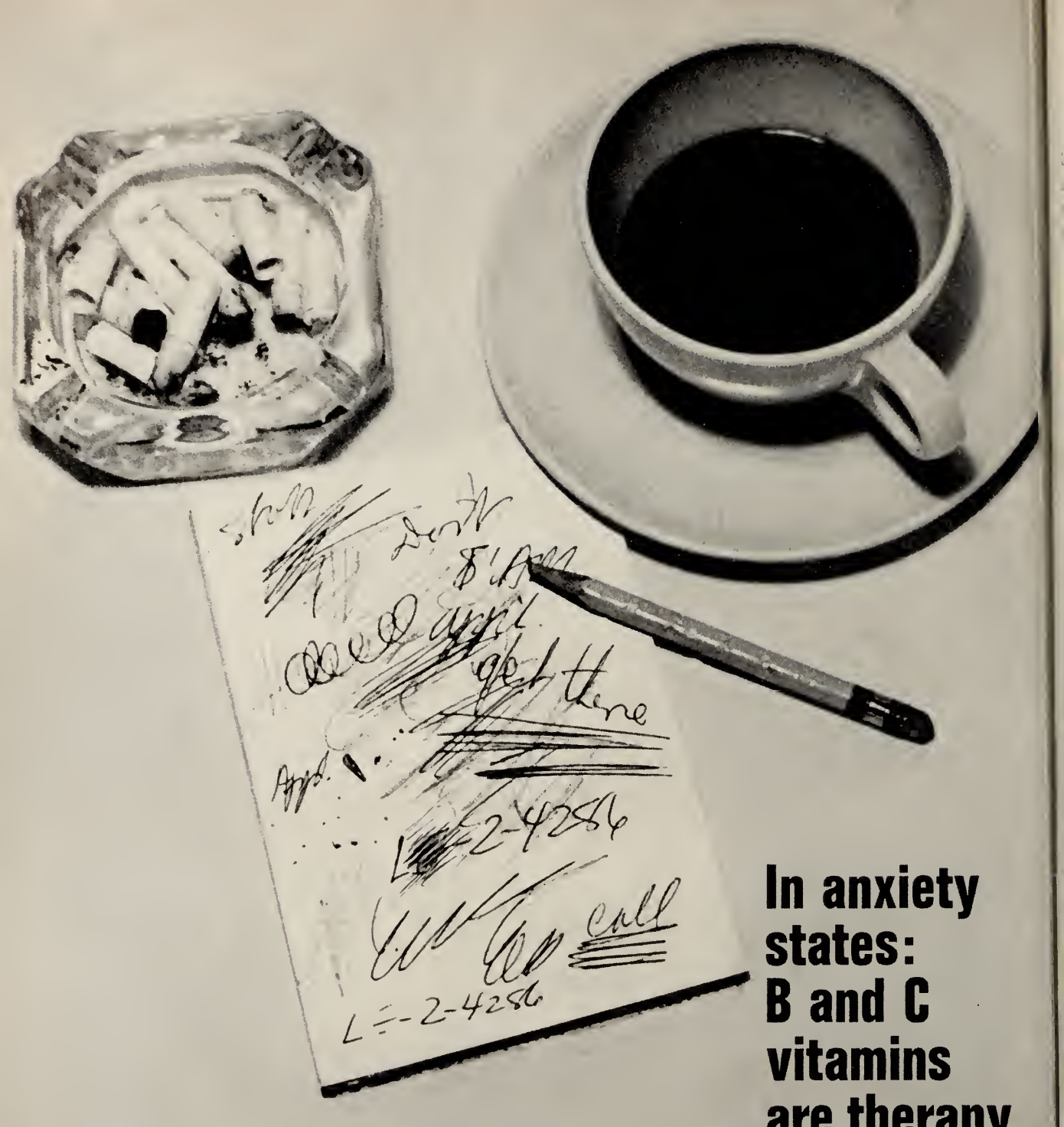
resuscitation, protection of wounds, splinting of fracture, and at all times, calm deliberate gentleness in handling or moving the victim.

In summary, water rescue offers many problems that are deserving of further medical study. The use of the MSS Winch Board for bringing victims into a boat or onto a low dock has been described.



FIGURE 7. At the earliest possible moment the winch operator assumes a sitting posture. From this step of the operation laying legs of the winch board flat pull the board and victim into the boat.

(Continued on Page 755)



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(Continued from Page 753)

The assistance of Captain Robert A. Bauer, MSC, USAF; A1C Lelan Milan, S/Sgt. Ozrow A. Ellis, and S/Sgt. Adolph F. Baugh in developing applications of the MSS Winch Board is gratefully acknowledged.

References

1. American National Red Cross, Life Saving and Water Safety, Doubleday and Company, Inc., 1956, Garden City, New York.

2. Swann, H. G., Resuscitation in Semi-Drowning, in Artificial Respiration, edited by Whittenberger, James L., Hoeber Medical Division, Harper and Row, 1962, New York.

3. Gordon, Archer S., Pulse of Life, Movie, Pyramid Film Producers, 1962, Hollywood.

4. The St. John Ambulance Assn., The St. Andrew's Ambulance Assn. and the British Red Cross Society, First Aid, page 69, Hills and Lacy Ltd., 1965, London.

5. American National Red Cross, Life Saving and Water Safety, Doubleday and Company, Inc., 1956, Garden City, New York.

6. Navpers, Standard First Aid Training Course 10081, U. S. Government Printing Office, 1955, Washington, D. C.

EDITOR'S NOTE: *Colonel Kossuth has had a number of responsible assignments in USAF Medical Service. He is certified in Public Health and Aviation Medicine by the American Board of Preventive Medicine. The author is past president of the American College of Preventive Medicine. He is a Fellow of the American Public Health Association and a Fellow of the Aerospace Medicine Association.*

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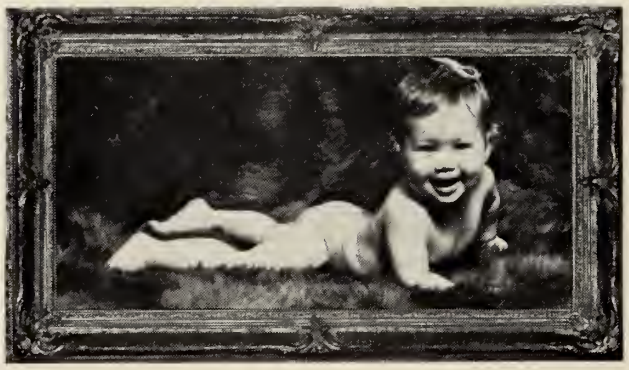
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St. Vincent Hospital	St. Bernard College; Troy State Teacher's College	J. A. Cunningham, MD	3 yrs.	12	8	Jan-July-Sept	None
South Highlands Infirmary		W. F. Scott, Jr., MD	3 yrs.	12	5	Jan-July-Sept	None
University Hospital	University of Alabama	J. V. Straumfjord, Jr., MD	3 yrs.	12	30	Feb-Jun-Sept	None
Fairfield							
Lloyd Noland Hospital	Troy State College	H. G. Davis, Jr., MD	3 yrs.	12	10	Quarterly	None
Gadsden							
Holy Name of Jesus Hospital	Jacksonville State College	J. D. Bush, MD	3 yrs.	15	6	Feb-Sept	None
Mobile							
Mobile Infirmary	Alabama College; Auburn University; Howard College; Spring Hill College	E. B. Wert, MD	3 yrs.	18	12	June	None
Providence Hospital	Spring Hill College	T. D. Davis, MD	3 yrs.	12	4	July	None
Montgomery							
St. Margaret's Hospital	Troy State College; Auburn University	W. B. Sorrell, MD	3 yrs.	12	10	Jun-Sept	None
Phenix City							
Chattahoochee Valley-Homer D. Cobb Memorial Hospital		J. M. Webber, MD	3 yrs.	13	2	Varies	None
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Druid City Hospital	Howard College	J. S. P. Beck, MD	3 yrs.	12	10	Feb-June-Sept	None

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* * *

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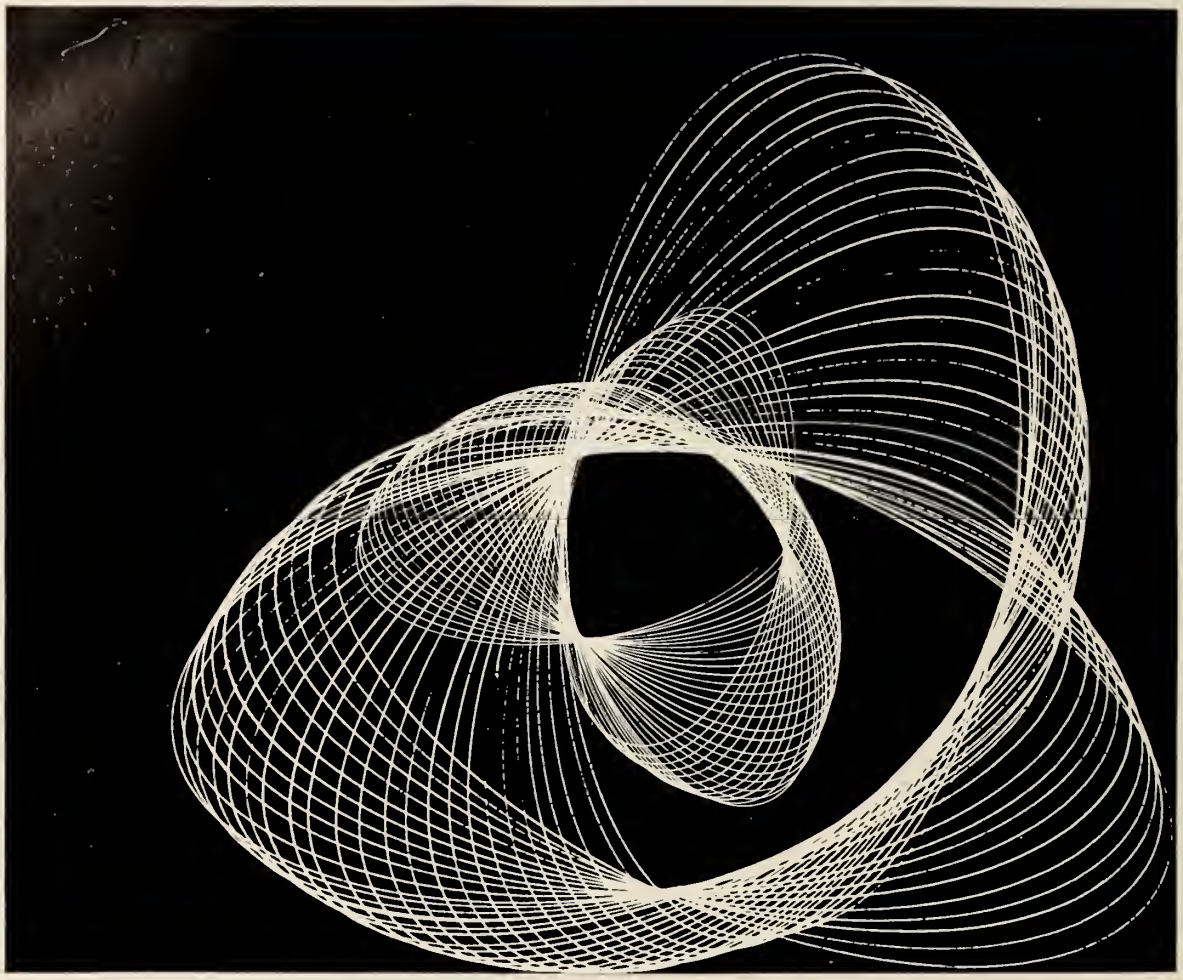


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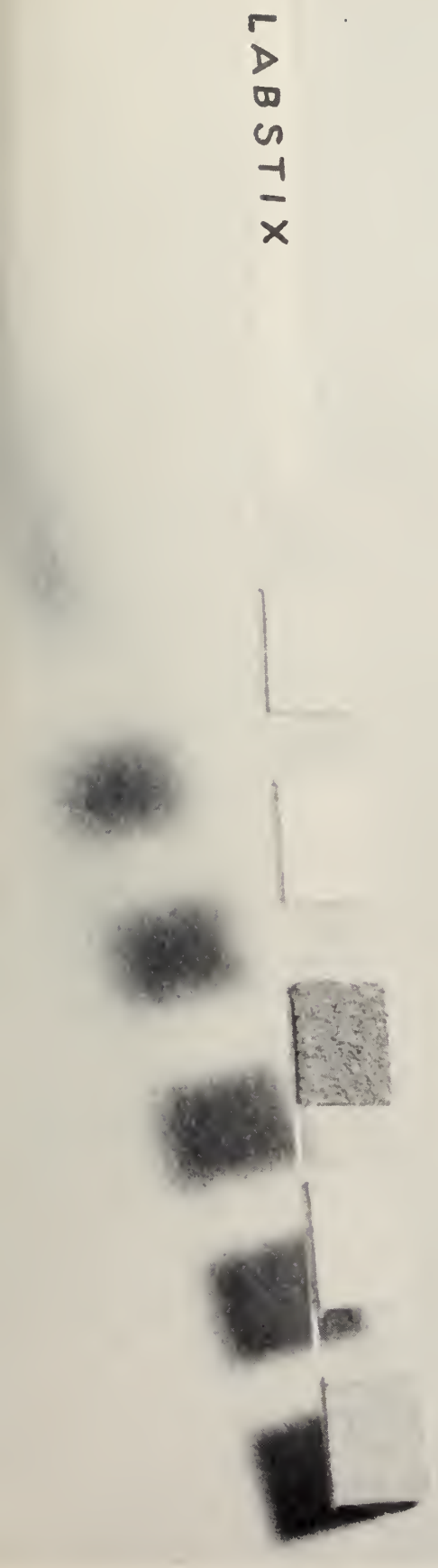




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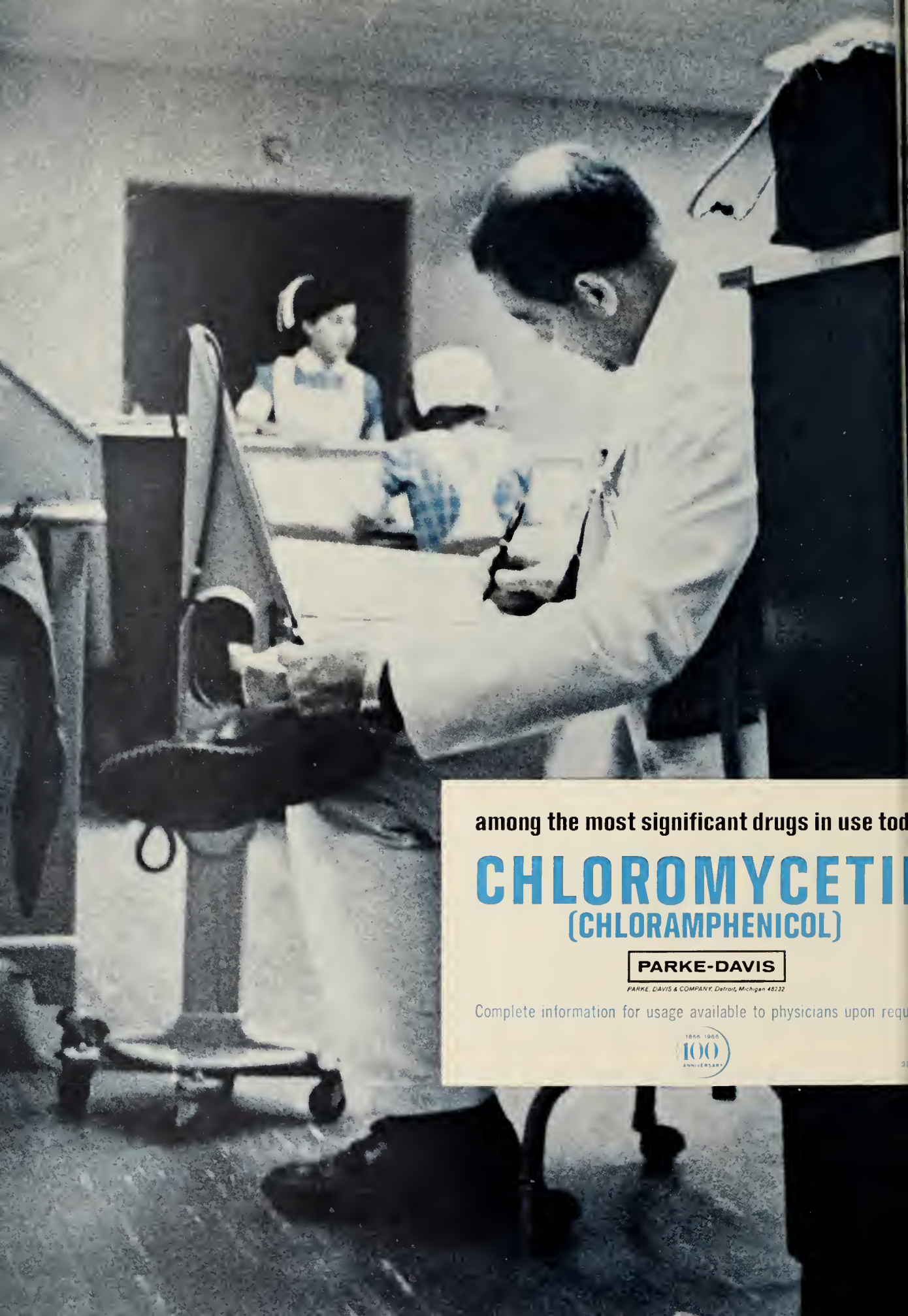
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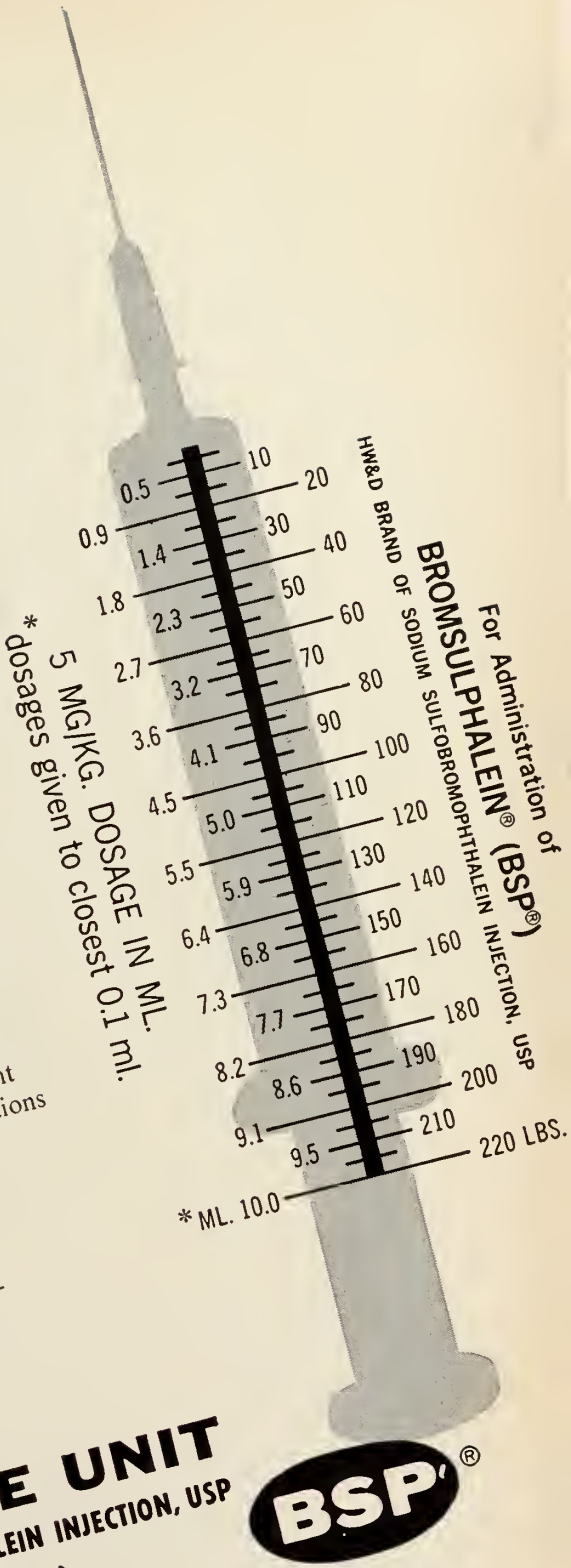
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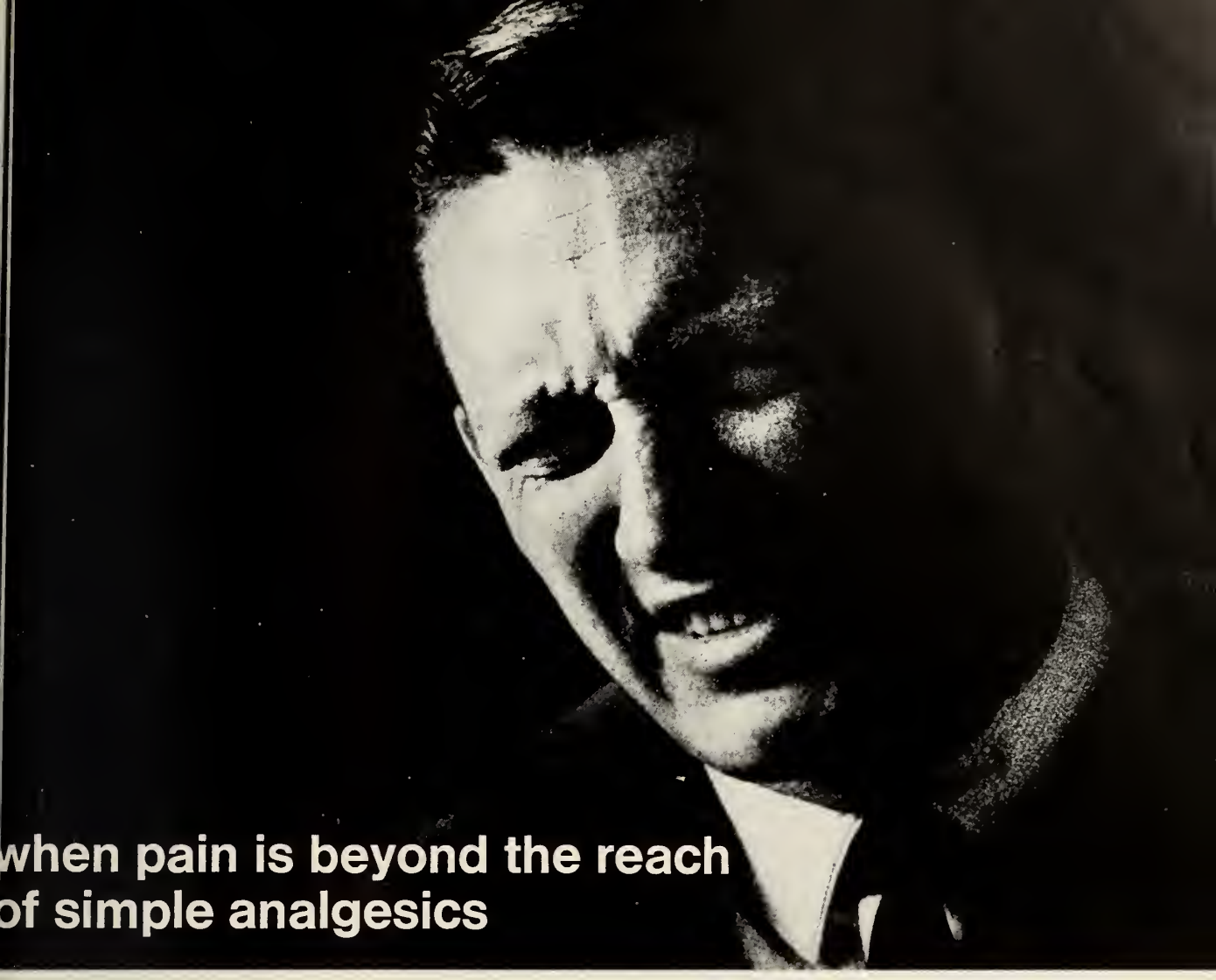
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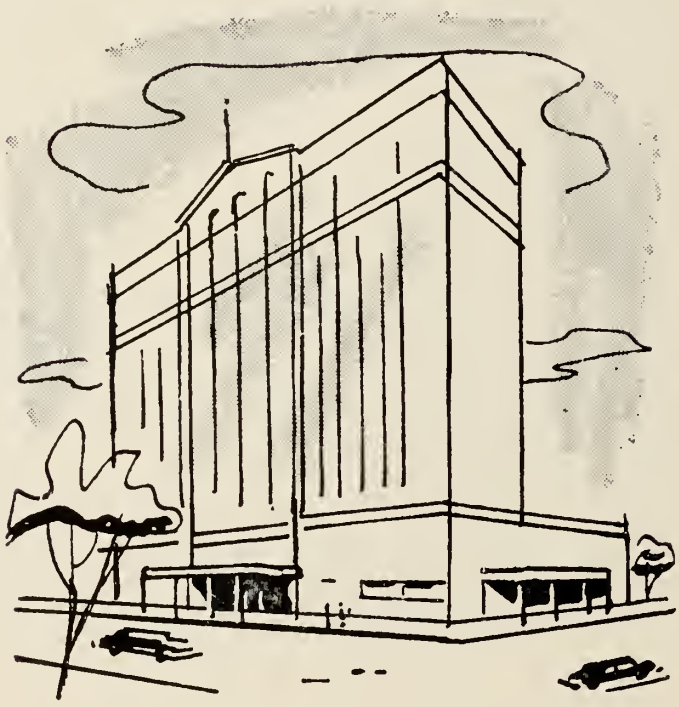
Side effects have been minor. Occasionally gastric distress, weakness, sedation or dizziness occur. Reversible cholestatic jaundice has been reported on rare occasions. However, in 4,653 patients treated with chlormezanone, 97.7% had *no* side effects.[1] *Contraindication:* just one: sensitivity to aspirin. *Dosage:* Adults, usually 2 tablets three or four times daily. Children (from 5 to 12 years), 1 tablet three or four times daily.

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President's Page



On December 10, 1965 American Medical Association representatives on the Physician Participation Subcommittee offered eight suggestions to the Social Security Administration which it believed would help achieve some level of success in implementing Public Law 89-97. These eight suggestions were:

1. Simple certification as to the medical need of covered services through a stamp on the initial order sheet.

2. No required recertification as to continuing medical need, before the 20th day of hospital care.

3. Limitation of all subsequent recertifications.

4. Limitation of state agency involvement in evaluating the effectiveness of utilization review committee work.

5. Co-operation between carriers and state and local professional associations in establishing methodology of reasonable fee determinations.

6. Utmost simplicity in claims forms.

7. A strong reliance upon the integrity of physicians; and

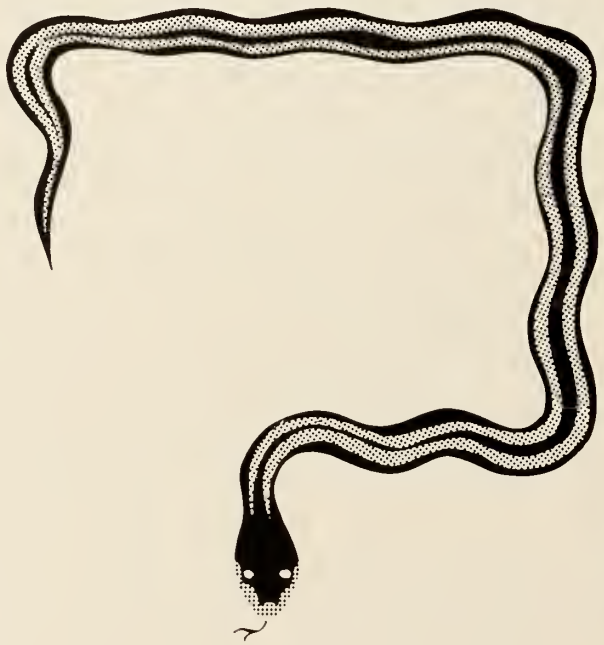
8. A studied regard for the "prohibitions" against any federal interference as clearly stated in Section 1801 of the Act.

Although only a few of the final regulations have been promulgated at the present time, most of the evidence would indicate that these suggestions of the American Medical Association have been largely accepted. Certification and recertification have been simplified. Utilization Review Committee work has been largely delegated to the medical staffs of the various hospitals. A very simple one-page claim form has been approved which allows a simple check to designate whether the physician's fee is on a direct billing basis with his patient or on an assignment basis with the carrier. In this regard it might be worthwhile to note that the American Medical Association has pointed out repeatedly that the law allows physicians to either bill their patients directly or to take an assignment of benefits due from the carrier for the professional service rendered. In the direct billing method, the physician deals directly with the patient on the basis of the usual fee and expects the patient to pay his bill. The patient will then submit the receipted bill to the Part B carrier "in Alabama, Blue Cross-Blue Shield of Alabama" who will reimburse him with 80 per cent of the "carrier-determined" reasonable fee for the service rendered. The other method, that of taking an assignment, requires that the physician accept the carrier determined schedule of reasonable fees as full payment and the carrier would pay the physician the 80 per cent of this fee designated by law with the patient paying the remaining 20 per cent.

(Continued on Page 769)

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1. Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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PRESIDENT'S PAGE

(Continued from Page 767)

In establishing a basis for the reimbursement of physicians by the carrier on a reasonable and customary basis as required in the law, the Government has seen fit to establish three criteria for the determination of such fees. These criteria are spelled out in Section 1842 "B" "3" of the law. They are as follows:

1. The physician's fee shall be his customary charge for the service rendered.

2. The fee must be consistent with the prevailing charges in the locality for similar services, and

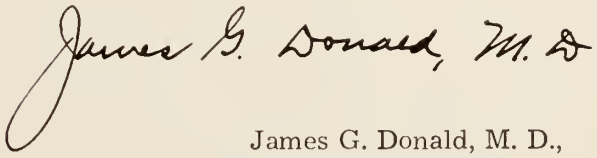
3. The fee must be not higher than the charge applicable for a comparable service under comparable circumstances to other patients insured by the carrier.

Since all three of these criteria must be met, some method must be determined by the carrier for establishing this basis of reimbursement.

Since Blue Cross-Blue Shield of Alabama has been designated as carrier for Part B of Public Law 89-97, the president has proposed that the fairest and most efficient way of determining the reasonable and customary fees in the State of Alabama would be by means of an individual survey sent to all physicians practicing in the state. Such a survey would ask for the normal and customary charges for the services most frequently rendered by these physicians. In this way, individual charges of the doctors would be determined and also the prevailing fees applicable in the locality for similar services. Such a survey would in no way bind the physician to any contract or obligation, but would simply be done as a fact-finding activity by the carrier. It would seem that this is the only reasonable method by which the carrier can be reimbursed on a usual and customary basis.

If the suggestions of the American Medical Association which were originally listed are accepted and embodied in the rules and regulations, the road ahead in implementation of Public Law 89-97 will be less rough than anticipated. If they are not accepted, and lengthy and cumbersome forms for admission certification and recertification are required, if federal or state agencies interpose themselves in policies, or if the carriers are required to establish fee schedules as "reasonable," or if the law in any way seriously disrupts existing patterns of practice and seriously interferes with the physician's proper care of his patient, it seems likely that many physicians will exercise as their individual legal right not to participate in the program.

Serving as your president during the past year has been an extremely interesting and challenging task. This has been a period of transition in many ways and many difficult problems lie ahead. However, I am sure that my successor, Dr. J. O. Finney, will receive the same measure of co-operation from all members of the Medical Association as have I.



James G. Donald, M. D.,
President

NUTRITION INFLUENCE ON HEALTH AND LONGEVITY

Different nutritional regimens affect the prevalence of many age-associated diseases, the life span of the individual and, as a result, mortality patterns of population. In studies of animals, the smallest number of rats having tumors was found in the group in which intakes of protein, carbohydrate, and total calories were low. In earlier studies, the greatest life expectancy and the lowest incidence of kidney lesions were found among rats whose intakes were low in protein, carbohydrate, and calories. (M. H. Ross and G. Brass: "Tumor incidence patterns and nutrition in the rat." *Journal of Nutrition*, November 1965).

First aid for a button popper



Second aid for a button popper



By providing combined anorexigenic-tranquilizing action, BAMADEX SEQUELS Capsules help your nonshrinking patients to establish new patterns of eating less. The amphetamine component suppresses the appetite, while the meprobamate helps allay nervousness and tension. And for most patients, the *sustained* release of the active ingredients provides convenient one-capsule-a-day dosage.

Side Effects commonly associated with either component are possible but, to the extent these are dose-related, they should normally be mild and infrequent, since the total dosage of each component on the usual one-capsule-daily regimen is quite low. Also, the sedating effect of meprobamate and the stimulating effect of d-amphetamine sulfate tend, to some extent, to cancel each other out. Adverse effects not peculiar to either component have not been reported. Side effects associated with d-amphetamine sulfate include: insomnia, excitability, increased motor activity, confusion, anxiety, aggressiveness, increased libido, hallucinations, rebound fatigue, depression, dry mouth, anorexia, nausea, vomiting, diarrhea and increased cardiovascular reactivity. Effects associated with meprobamate include: skin rash, nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema, fever and transient leukopenia; also, very rarely, fainting spells, angioneurotic edema, bronchial spasm, hypotensive crisis, anuria, stomatitis, proctitis and anaphylaxis. Other serious effects have occurred after concomitant administration of meprobamate and other drugs. Massive overdosage may produce grave effects.

Precautions: BAMADEX SEQUELS should be given only under close supervision to patients hypersensitive to sympathomimetic drugs, with cardiovascular or coronary disease or who are severely hypertensive; to emotionally unstable persons and to epileptics. Patients should be cautioned not to drink alcoholic beverages while on the drug, and not to drive vehicles if they become drowsy. In all patients kept on the drug for long periods, the drug should be withdrawn gradually to avoid possible serious reactions.

Contraindications: Hyperexcitability, agitated prepsychotic states and a history of previous reactions to meprobamate.

Bamadex® Sequels®

d-amphetamine sulfate (15 mg.) and meprobamate (300 mg.) Sustained Release Capsules

LEDERLE LABORATORIES • A Division of American Cyanamid Company, Pearl River, New York Lederle

6655



THE PRESIDENT IS MORE THAN A FIGUREHEAD

As this issue of *The Journal* is readied for the press, we are reminded of the fact that it is only a matter of days until the responsibilities of the presidency of the Medical Association of the State of Alabama are lifted from the capable shoulders of James G. Donald and transferred to the tried-and-proven J. O. Finney, Sr.

It is possible that hardly more than a handful of the members of this Association fully comprehend the tremendous demands now being made on their chief executive. The honors of the office are nothing compared with the time and energies spent in directing the complex affairs of the organization.

The presidency is rendered more difficult at this time by the enactment of legislation by the national Congress aimed at achieving creeping socialization of medicine. This "womb to tomb" health program for the so-called indigent—incomprehensible as written—will be enlarged and made even less understandable by the adoption of hundreds of rules and regulations incident to its implementation.

The responsibility for analyzing each revolutionary development and assessing its effect on organized medicine is now being shared by the American Medical Association and the several state associations. This has required the President to attend dozens of orientation conferences at both the state and national levels, and then to translate his interpretations into easily-understood language for dissemination to the mass of his membership.

The personal sacrifices demanded of the President of a state medical association cannot be measured in either time or money. Fortunate indeed is he whose practice permits him to be absent for numerous and long periods of time. The medical association president who is determined to serve effectively must be prepared to virtually forsake his professional and personal life for the duration of his tenure.

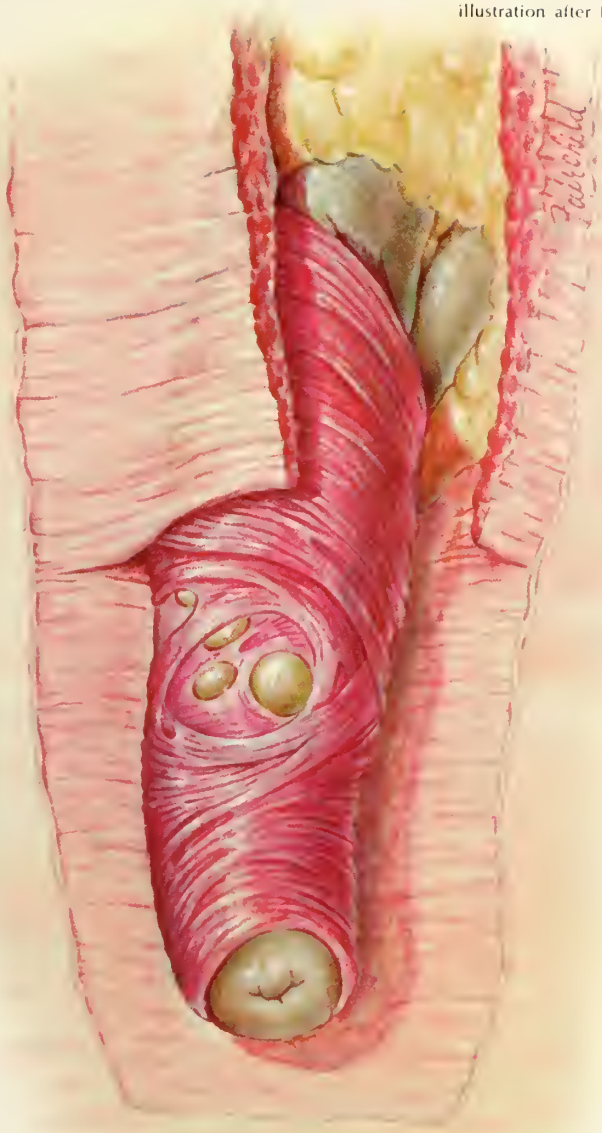
No longer is the office of president merely the symbol of medical leadership or the reward for faithful adherence to the principles of an honored profession. It is a job for a man of vision, of energy, and of determination to serve the best interests of organized medicine at whatever personal sacrifice may be demanded.

Fortunate indeed is the Medical Association of Alabama to have been served in its greatest hours of need by a succession of men who have met all of the criteria for unselfish devotion to duty.

To Dr. Donald and his predecessors of recent years *The Journal* extends an enthusiastic "well done." The qualities of leadership which they have exemplified deserve much more than mere words can express. Every physician in Alabama owes to these men an incalculable debt of gratitude.

(Editorials continued on Page 778)

illustration after Boyden



HOW IMPORTANT IS THIS

IN YOUR DIAGNOSES OF SMOOTH MUSCLE SPASM?

1966 Philips Roxane, Inc.

PERHAPS VERY IMPORTANT

The sphincter of Oddi is made up primarily of smooth muscle fibers. It permits the gall bladder to fill, regulates the flow of bile and pancreatic enzymes and in dysfunction is a primary cause of Biliary Dyskinesia. The sphincter of Oddi is but one of five major foci of smooth muscle spasm where SPACOLIN® (Alverine citrate) acts directly with rapid onset and long duration. No neurotropic side effects because Spacolin is a musculotropic counter-spasmodic unrelated to atropine or atropine-like drugs. Spacolin is not contraindicated in prostatic hypertrophy.

SPACOLIN® (Alverine citrate)

Each tablet contains: Alverine citrate 120 mg.

INDICATIONS: Smooth muscle spasmolytic for use in spastic colon, spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer,* achalasia, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations. DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, achalasia or pylorospasm, administer tablets ½ hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort. PRECAUTION: Caution is recommended when using in hypotensive patients. SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

*Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected.

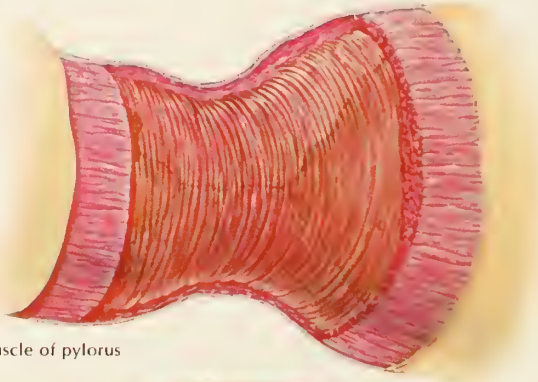
PHILIPS ROXANE LABORATORIES Division of Philips Roxane, Inc., Columbus, Ohio



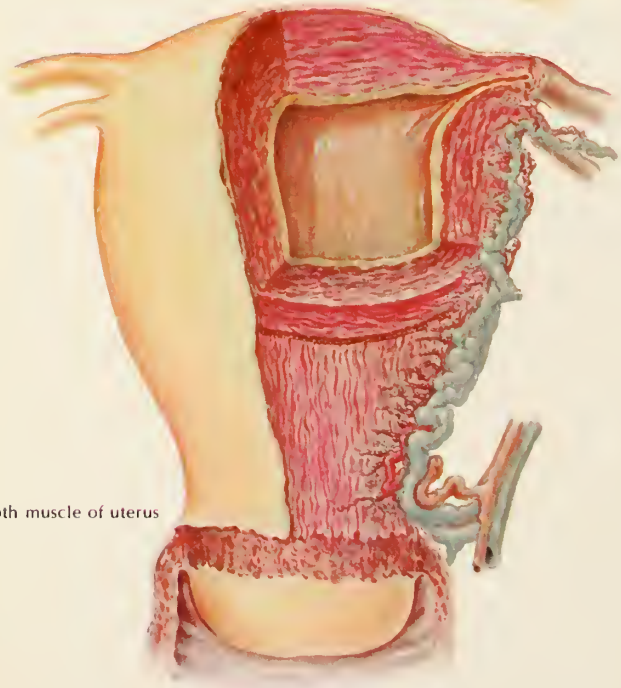
smooth muscle sphincter of Oddi



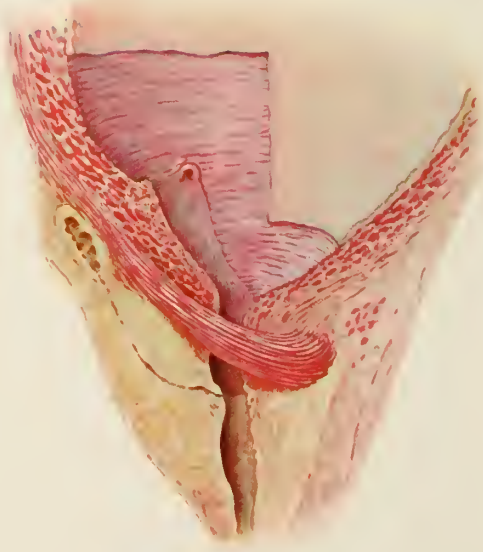
smooth muscle of colon



smooth muscle of pylorus



smooth muscle of uterus



smooth muscle of urinary bladder

DACTILASE®

Each tablet contains:
Dactil® (piperidolate hydrochloride), 50 mg.;
Standardized cellulolytic* enzyme, 2 mg.;
Standardized amylolytic enzyme, 15 mg.;
Standardized proteolytic enzyme, 10 mg.;
Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established.
**As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.



In chronic or acute indigestion, fluttery, gassy stomachs obtain prompt, gratifying relief through the antispasmodic, surface anesthetic and enzymatic activity of Dactilase. Dactilase decreases hypermotility and pain and reduces the production of gas. Dactilase does not induce stasis, but helps restore normal tone. It has little or no effect on enzyme secretions, but *adds* enzymes, thus contributing to the digestive efficiency of the patient.

Side Effects and Contraindications: Dactilase is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following, each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE | PRODUCTS FOR PATIENTS YOU SEE EVERY DAY

When uncontrolled diarrhea brings a call for help

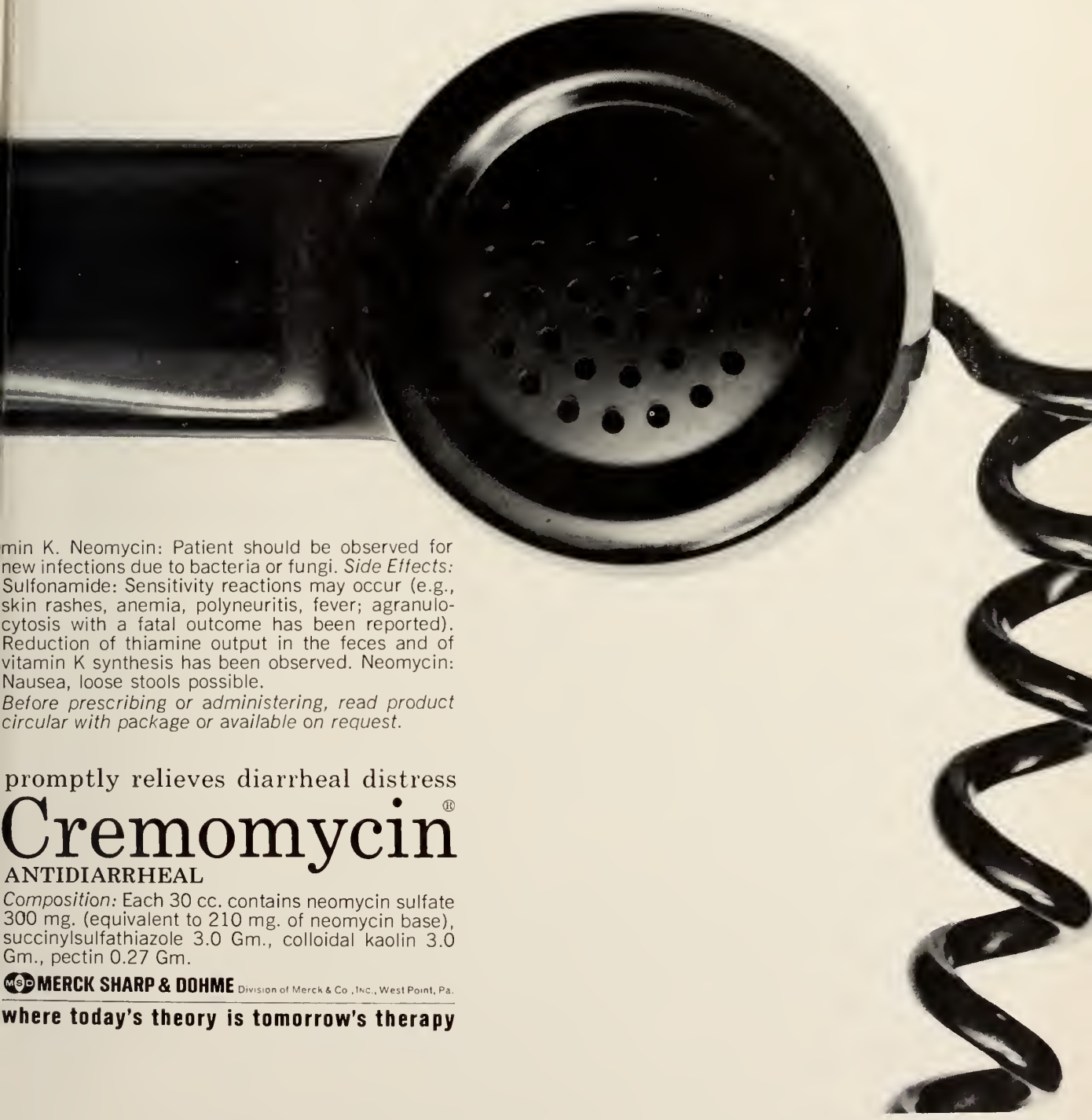


When the diarrhea sufferer has run the gamut of home remedies without success, pleasant-tasting CREMOMYCIN can answer the call for help. It can be counted on to consolidate fluid stools, soothe intestinal inflammation, inhibit enteric pathogens, and detoxify putrefactive materials—usually within a few hours.

CREMOMYCIN combines the bacteriostatic agents, succinylsulfathiazole and neomycin, with the adsorbent and protective demulcents, kaolin and pectin, for comprehensive control of diarrhea.

Indications: Diarrhea. *Contraindications:* Kaolin: Withhold if diverticulosis is present or suspected. *Precautions:* Sulfonamide: Continued use requires supplementary administration of thiamine and vita-

your ℞ for Cremomycin can provide relief



min K. Neomycin: Patient should be observed for new infections due to bacteria or fungi. *Side Effects:* Sulfonamide: Sensitivity reactions may occur (e.g., skin rashes, anemia, polyneuritis, fever; agranulocytosis with a fatal outcome has been reported). Reduction of thiamine output in the feces and of vitamin K synthesis has been observed. Neomycin: Nausea, loose stools possible.
Before prescribing or administering, read product circular with package or available on request.

promptly relieves diarrheal distress

Cremomycin®

ANTIDIARRHEAL

Composition: Each 30 cc. contains neomycin sulfate 300 mg. (equivalent to 210 mg. of neomycin base), succinylsulfathiazole 3.0 Gm., colloidal kaolin 3.0 Gm., pectin 0.27 Gm.

MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

FIGHT AGAINST QUACKERY NEVER ENDS

"Physicians, as conservators of the public health, are bound to bear emphatic testimony against quackery in all its forms."

Is this a quote from proceedings of the American Medical Association's Clinical Convention in Philadelphia in December?

The meeting was in Philadelphia, but the year was 1847!

So you see, from its very inception 118 years ago, the American Medical Association has been battling quackery and it is dedicated to a continuation of this warfare against wasting the nation's health and its health care dollar . . . of fighting fraud at the bedside of ill and desperate people.

For, as long as there are human beings, there will be human nature . . . and quacks—pretenders to ability they don't possess—to take advantage of the fact.

The health quack is not so easy to spot these days. The stovepipe hat and the pitchman's hawking have gone. In their place are their space-age counterparts, the suave, apparently-sophisticated super salesmen with the Madison Avenue manners.

These merchants of menace, more insidious and unscrupulous than ever, have many new products, worthless diet fads, worthless food supplements, worthless cosmetic devices and treatments, worthless "cures" for everything —even into the area of brain-damaged children and other mental illness.

They bilk the undiscerning—the uninformed, the desperate, the unsuspecting of all ages—of millions of dollars a year. The estimates of the costs of medical quackery are at best calculated guesses, but they have gone as high as a billion dollars a year. And one authority in the field of quack-fighting has stated that "medical quackery each year costs more lives than all crimes in the United States."

It is this cost of life—and health—that has placed America's physicians in the front lines of the war on quacks. It is the insidious side effect of quackery with which medicine concerns itself—the delay in proper medical care that may cost life itself.

It is for this reason, too, that the medical profession is dedicated to education of the people about cultism—chiropractic and the other health sects that turn their backs on scientific medicine.

The House of Delegates of the American Medical Association said in 1933:

> "Either the theories and practices of scientific medicine are right and those of the cultists are wrong, or the theories and practices of the cultists are right and those of scientific medicine are wrong."

And in 1961, it said:

> "There can never be a majority party and a minority party in any science . . ."

After the quack or the cultist has extracted his pound of flesh—after the damage is done and after the sick may have become the dying because of the delay in proper care—scientific medicine usually is called upon to pick up the pieces.

Medicine has tried and will continue to try to do that job, too, but how much easier the job would have been—how many lives would have been saved—if . . .



THERE IS A DUTY TO BE PRESENT

The 105th Annual Session of the Medical Association of the State of Alabama will be held April 22-23 at Mobile. Every member owes it to himself to lay aside all other business and make this contribution to the future of his profession.

There will be exciting revelations of advancements in the practice of medicine, new scientific exhibits, speeches by knowledgeable men on matters of direct concern to every physician, and valuable reports on Association affairs.

Perhaps as important as any of the above features is the opportunity for members of MASA to gather with their contemporaries from other sections of the state, renewing old friendships and making new friends. From these informal get-togethers will come a new respect for, and understanding of, your fellow doctors.

Difficult problems now confronting organized medicine and the Association—problems which endanger or have far-ranging consequences for physicians—are certain to be debated formally or informally during the Session.

It will advantage every member of MASA to be present and make his opinions known to others. Only through concerted action and full knowledge of all issues can Medicine remain free.

(Editorials continued on Page 782)



for psychiatric treatment

Peachtree Hospital, located in Atlanta, Georgia, is a complete psychiatric, alcoholic and drug addiction treatment facility accredited by the Joint Commission on Accreditation of Hospitals ☐ The hospital has 65 beds, 47 of which are devoted to the care of psychiatric patients and 18 of which, in a separate area, are for patients with acute cases of chronic alcoholism or drug addiction ☐ Treatment procedures include psychotherapy, electroconvulsive shock therapy, subinsulin coma and chemotherapy ☐ *We will be pleased to provide further information upon request.*

ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

peachtree hospital

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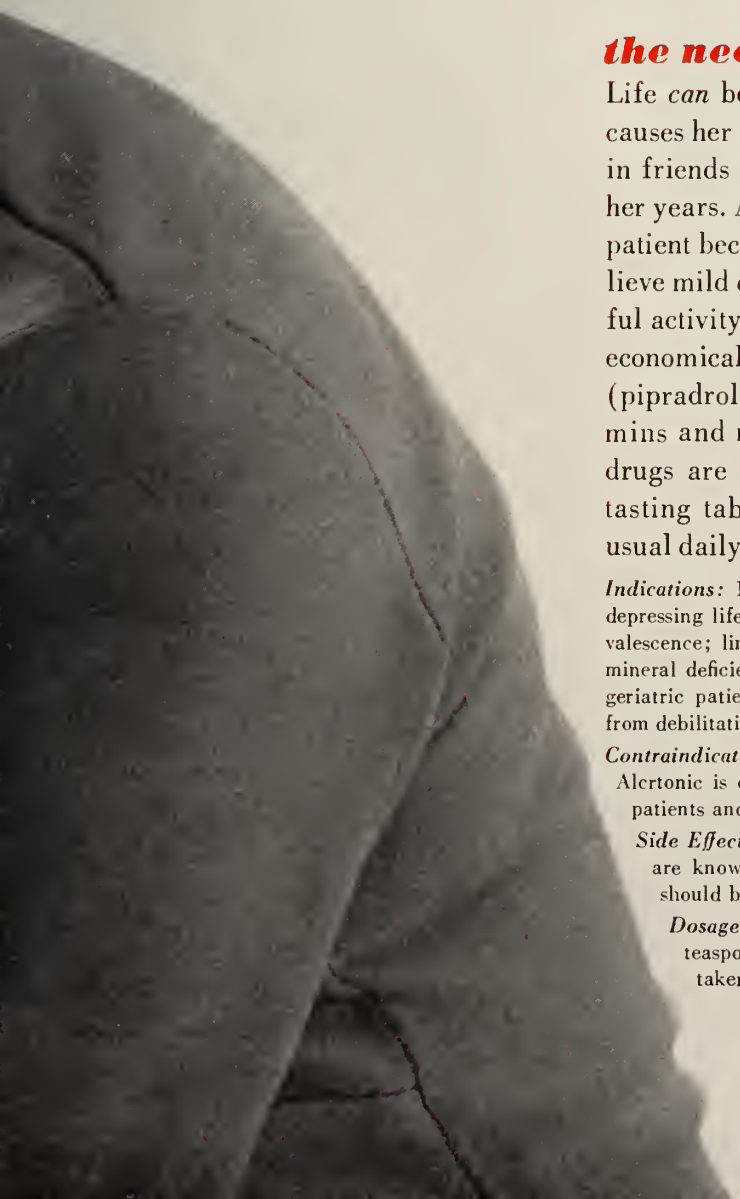
too young
to be so tired...



revive interest...restore activity promptly with Alertonic®

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline†, 100 mg.; inositol†, 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.



the need for a tonic knows no age

Life *can* begin at forty—except when functional fatigue causes her to feel tired all the time; to start losing interest in friends and surroundings; to look and act older than her years. Alertonic—*a prescription tonic*—can help your patient become her normal self again. Alertonic helps relieve mild depression, revive interest and restore purposeful activity promptly...with a formula that is efficient *and* economical. Alertonic contains a mild central stimulant (pipradrol hydrochloride), 15% alcohol, essential vitamins and minerals. No hormones or MAO-inhibiting drugs are included. No iron. No iodine. One pleasant-tasting tablespoonful before each meal comprises the usual daily dose.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS-stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive-compulsive states.

Side Effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

THE WM. S. MERRELL COMPANY
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Cincinnati, Ohio/Weston, Ontario

Merrell

Guest Editorials....

MIND POLLUTION CAN BE DANGEROUS

The Medical Society is concerned with pollution since it endangers the health of the community. This concern embraces air pollution, water pollution and food pollution. But there is yet another such evil which may be the most important and destructive of all —mind pollution.

This may be defined as the technique of misrepresentation and using wholly or partially false information to condition the mind of the public to accept the goals of those who promote them. A talent for distortion is a prerequisite to mold the public mind into a receptive mood.

The practice of mind pollution is utilized increasingly by many groups. We have seen it used by our government in the duplicity of the campaign for Medicare, and by local authorities in creating a climate for promotion of larger controls of hospitals and medical practice. The tools of this deceptive practice include perfidious perversions of the facts, of biased surveys of medical care, conducted by individuals with a vested interest in the outcome. In this instance and in others, the practicing physician is treated as a non-person whose opinion is disdained. These tools have been used by officials and labor unions to justify their selfish aims and desires. Their interest and purpose is to establish controlled systems of medical practice. Ostensibly the objective of providing good medical care is laudable. But the practical and real results of the systems proposed are deplorable to the physician and detrimental to the patient. We are led to believe that their endeavors are in the public interest while, in reality, they are serving their own interests.

It has been stated that the Welfare State is more for the welfare of the politician than for the welfare of the people. A timely example is the war on poverty which is floundering in wasteful chaos which benefits the politician but scarcely the poor.

The noble dreams proposed by our social planners have very little to do with quality. It is in the nature of bureaucratic systems to be wholly quantitative and materialistic. Doling out dollars does not in itself promote better health.

How do we become ensnared by the social planners? The process is a deliberate piece of demagoguery. Our officials whip up a semblance of popular demand with the aid of pressure groups to force the people to accept their ideas. The process approaches the technique of the "Big Lie" which is being practiced by those who not long ago condemned it in others. To further its success they are aided and abetted by the press and other media of communication. Once such a distortion of the truth is published the damage to the public mind is done. A later correction or retraction has little effect. Jonathan Swift remarks on the controlled and timely lie: "Falsehood flies, and truth comes limping after it, so that when men come to be undeceived, it is too late." Subjected to such pressures, it is practically impossible for the people to get across to their legislators that they can really manage without all these controls

Reprinted from the bulletin of the Medical Society of the County of Kings and Academy of Medicine of Brooklyn.

and elaborate largess. An air of resignation sets in—and the evil is accepted with a feeling of futility.

The recent transit strike in New York City is a glaring example of mollifying the public mind while allowing the labor union to flout the law. The extent of the harm done to the public health has not been revealed and may never be determined. There was utter disdain for the right of the people to be upheld under the law. Then to add to the iniquity there was failure to punish those who disobeyed the law. All was forgiven in an atmosphere of cordiality between the authorities and the guilty.

Our legislators state that since they enacted the law prohibiting the corporate practice of medicine by hospitals, they have the right to make exceptions to the law. If such is the case, one may well ask under what circumstances and upon what basis are these exceptions made? This rationalization could be extended to include any law enacted. Are our laws just instruments of convenience for our politicians and pressure groups? If this is true, our society is built on shifting sands rather than a firm foundation. It would seem evident that those in whom we entrust our government are only self-serving and readily betray our faith and trust.

Another example of this specious thinking, which is reminiscent of George Orwell's "double think" is the matter of proving need for governmental financial benefits. In the argument for Medicare it was loudly proclaimed that the "means test" is proper and acceptable under the Federal Aid to Education Bill. Consistency in its thinking is not a virtue of government—but rather fit the reasoning to the need.

These instances of legislative delinquency set a poor example to the average citizen and weaken his respect for the law. If a legislator can treat the law so lightly, how is the citizen to maintain his faith in the legislator or the law?

It is time—and it may well be too late—that serious reflection and careful consideration be given to the trend of success of these destructive forces—destructive of personal dignity and personal liberty—of the great qualities and virtues of the individual of self reliance and self respect. These are the true attributes of great accomplishments. It is time that we seek and demand the whole truth. The public's credulity may be great, but it is not infinite. Let us recognize "mind pollution" for what it is—and it can appear in subtle forms. Let us be more perceptive and alert to the dangers that confront us—before it will be really too late.

Vincent J. Tesoriero, M. D.

UNITY IS ESSENTIAL

This is the time for reason—not prejudice. Knowledge without judgment yields only prejudice, hence we must utilize the best judgment to effect the most reasonable approach to our common problems.

Individually we must maintain the private practice of medicine unfettered, so that the quality of medical care to our patients will not suffer. This requires only one thing—that of continuing our present interpersonal responsibility between ourselves and our patients, without admitting any third party interference.

Collectively we must present ourselves as a unified organization, ever watchful that the legislative powers of our government shall not intrude upon the freedom of our profession. To this end, we must individually deny ourselves the luxury of acting independently. For if we are divided within our organization we shall lose the freedom of the private practice of medicine as we have known it; our patients will lose individual identity in their health care; and those who will take our place in the future of medicine will condemn us.

G. C. Andersen, M. D.

President, Los Angeles
County Medical Society



The Pain Is Gone

Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

'Empirin'® Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

Keeps the Promise of Pain Relief

BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.



DR. J. O. FINNEY, SR., NEXT MASA PRESIDENT

If the Medical Association of the State of Alabama was looking for a busy man to take over its helm as President, it needed to search no farther than James Owen Finney, Sr., of Gadsden.

Like so many other dedicated leaders of MASA, Dr. Finney has crowded into his professional and personal life a multiplicity of other responsibilities ranging from service on the Board of Censors and the Alabama State Board of Mental Health to a professorship at the Medical College of Alabama and consultant in Medicine to the Veterans Administration Hospital in Birmingham.

Born in 1907 at Florence, Ala., Dr. Finney was graduated from the public schools of that city and received his A. B. and M. D. degrees from Vanderbilt University. He served his internship in Medicine at Vanderbilt University Hospital.

He has practiced medicine in Gadsden since 1936 with the exception of time out to serve in the Medical Corps during World War II.

A Diplomate of the American Board of Internal Medicine and a Fellow of the American College of Physicians, Dr. Finney currently is head of the Department of Medicine at the Holy Name of Jesus Hospital in Gadsden. He is a past president of the Alabama Heart Association, the Alabama Society of Internal Medicine, the Etowah County Medical Society, the Etowah County Mental Health Association and the Vanderbilt University Medical Alumni Association.



Dr. J. O. Finney, Sr.

Dr. Finney's service with MASA began in 1950 when he was elected Vice President of

(Continued on Page 787)



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.



A REPORT ON THE ELDERCARE CAMPAIGN OF 1965

The annals of the Medical Association of the State of Alabama would not be complete without a report on the Eldercare campaign of 1965 and the magnificent performance of physicians and members of the Auxiliary. This was a desperate, last-ditch campaign designed to defeat the King-Anderson Bill, later refined by Rep. Wilbur Mills as H. R. 6675, popularly known as Medicare, and substitute in its stead a program which would have accomplished the same results without a burdensome payroll tax on the working men and women of the nation.

Immediately after the landslide victory of Lyndon B. Johnson in November, 1964, it became apparent that organized medicine and the political conservatives could no longer stave off enactment of sweeping legislation to socialize the health care of the aged and indigent. The President announced to the nation that he considered his election a mandate for passage of a Medicare law which had been defeated in successive Congresses for a quarter of a century.

The American Medical Association under the leadership of Dr. Donavan S. Ward came forth in early January, 1965, with a program known as Eldercare, which would have amended Title I (Old Age Assistance and Medical Assistance for the Aged) and Title XVI (Aid to the Aged, Blind, or Disabled, or such aid and Medical Assistance for the Aged) of the Social Security Act to add a new section under which a State with an MAA program would have been authorized, in its discretion, to provide premium payments for health insurance coverage under voluntary private health insurance plans under existing law. A State wishing to participate in the program would have been required to enter into contracts or other arrangements with private insurance carriers as deemed appropriate.

As envisioned, Eldercare would have provided a wide range of hospital and medical benefits for the elderly including physician's care, surgical cost, drugs, hospital and nursing home services.

(Continued on next page)

DR. FINNEY

(Continued from Page 785)

the Northeastern Division. He also has held the office of Chairman of the Public Relations Committee and has been a member of the Board of Censors since 1953. His present term would have expired in 1968 but he is resigning to accept the office of President.

He also holds membership in the American Medical Association, the Southern Medical Association and the American Rheumatism Association.

His non-medical activities are almost as varied. He is a member of the Board of Directors of the American National Bank of Gadsden and of the Life Insurance Company of Alabama. He is a past chairman of the Official Board of the First Methodist Church of Gadsden and a Trustee of Snead College at Boaz. Other activities include membership in the Gadsden Country Club and the Downtown Club of Birmingham.

Dr. Finney is married to the former Margaret Pride of Florence. They live with their daughter, Lane, at 2712 Hilltop Circle in Gadsden. A son, Dr. J. O. Finney, Jr., is following in his father's footsteps as a graduate of Vanderbilt University School of Medicine and is now an intern at University Hospital in Birmingham.

Among Dr. Finney's proudest assets are two young granddaughters. One night last summer when urgent Association business forced the Central Office to call him at his vacation cottage on Guntersville Lake, he interrupted the conversation thusly:

"Just a minute. One of these little girls is jumping up and down on my stomach."

THE ELDERCARE CAMPAIGN

(Continued from Page 787)

It was felt that Eldercare offered more care for the elderly who actually needed help, but cost less than Medicare because it would not provide benefits for the wealthy at the expense of the wage earner. Eldercare would not have required a new payroll tax but would have been financed wholly by federal-state funds through existing Kerr-Mills legislation which already had been implemented in Alabama and most other States.

The AMA felt that Eldercare would assure free choice of physician and hospital without controlling federal regulations such as now exist under Public Law 89-97.

Consequently, the Eldercare bill was introduced into the Congress by Rep. Curtis of Missouri and Rep. Herlong of Florida as H. R. 3727.

A third bill was introduced by Rep. Byrnes of Wisconsin which would have given all persons 65 or older benefits equivalent to those available to federal employees under the government-wide Indemnity Benefit Plan. This bill would have been financed by the beneficiaries, based upon their ability to pay and through general federal revenues.

It is significant now that P. L. 89-97 (Medicare) which finally emerged from the Congress on July 9, 1965, was a combination of all three of these bills and that Eldercare's programs and procedures have been solidly embraced under Title XIX of the law with the exception that it extends benefits to the indigent of all ages as well as to maternal and child welfare cases, crippled children and numerous other recipients of public assistance.

With this background information, it is now possible to evaluate the performance of Alabama physicians in the nationwide fight to halt the encroachment of federal agencies into the practice of medicine.

Alabama's campaign to win public support for Eldercare was conducted vigorously during the last four months of the administration of President E. B. Glenn and the first four months of the administration of President James G. Donald. From the beginning all activities received wholehearted support from both the Board of Censors and the Board of Trustees.

From the outset it was apparent that organized medicine was not alone in the fight against H. R. 6675. Business, industry, and farm groups were actively opposed to the legislation and ably assisted the Association in every way requested. State and local chambers of commerce gave wide publicity to the campaign and a majority of the daily and weekly newspapers in Alabama editorialized against the bill.

On January 9 and 10, 1965, Dr. J. Garber Galbraith, Chairman of the Committee on Aging and the Indigent, attended a national conference in Chicago on the Kerr-Mills program as it was then being operated in most of the States. It was generally conceded that the Kerr-Mills law had many shortcomings and that unless these could be corrected, the liberal clamor for broader legislation would mount. At a meeting of the committee on January 17, 1965, the weaknesses in Alabama's law implementing Kerr-Mills were discussed and a series of recommendations made to correct them. However, before this corrective program could be launched, the Medicare-Eldercare battle had begun.

The basic plan to carry the fight for Eldercare to the grassroots was drafted by the American Medical Association. The burden was placed upon State medical associations to arouse public support for Eldercare through county medical societies. This groundswell of public opinion was designed to bring pressure upon members of the U. S. Congress, a majority of whom had opposed socialized medicine in previous sessions. The new 89th Congress, however, boasted the election of 17 new members committed to organized labor and its entire legislative program.

The Eldercare campaign was officially launched in Alabama on February 17, 1965,

(Continued on Page 790)

For cold hands and feet, nothing beats hot stoves—but they *are* awkward to carry around. Now Gerilid, in good-tasting take-along chewable tablets can provide rapid vasodilation of peripheral circulation, bringing real warmth to the extremities and decreasing sensitivity to sudden temperature change. Patients *like* Gerilid and *know* they are getting relief.



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Each chewable tablet contains:
nicotinic acid (niacin) 75 mg. and
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Administration and Dosage: One or two chewable tablets 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation. The recommended dosage should not be exceeded.

Side effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is a concomitant administration of a coronary vasodilator.

Supplied: Packages of 50 chewable tablets.

Also available in liquid form as Geriliquid®, in bottles of 8 and 16 ounces.

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PRODUCTS
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THE ELDERCARE CAMPAIGN

(Continued from Page 788)

when the Board of Censors unanimously adopted a resolution calling upon physicians to support the plan in every way possible.

Responsibility for the campaign was assumed by President Glenn, working directly through the central office.

It was estimated that the cost of the campaign in Alabama would be the equivalent of $5 per member, one-half or $5,200 to be allocated by AMA and the remainder by MASA. With this fund in hand, "Operation Eldercare" was launched.

Pamphlets, newspaper ads, radio and TV spot announcements, letters to editors, news stories and speeches for delivery by county society leaders to civic clubs and other interested organizations were immediately prepared. Emphasis was placed on personal contact between physicians and residents of their community.

An appeal went out to medical auxiliaries to assist locally in every way possible, primarily by distributing pamphlets and other printed material to doctors' offices and public places.

Using printing equipment at Association headquarters, 150,000 copies of a pamphlet "Write Your Congressmen and Senators" were published and distributed in bulk to doctors for placement in patient waiting rooms. The pamphlet gave a synopsis of the Eldercare program and reasons for opposing the Medicare tax. On the reverse side was a map of Alabama showing each Congressman's district and listing his mailing address.

The first step in the campaign was to schedule 11 regional meetings to which all county society officers were invited for the purpose of explaining the Eldercare program to them and laying the formation for local campaigns. These meetings were faithfully attended by the four vice presidents, Dr. G. H. Stokes, Dr. H. E. Askin, Dr. S. J. Campbell, and Dr. E. L. Strandell. Members of the Board of Censors and the Board of Trustees also attended sessions in their areas.

Regional meetings were held as follows:

Date	City	Presiding
February 27	Dothan	G. Harmon Stokes, M. D.
February 28	Andalusia	Morgan J. Moore, M. D.
March 1	Montgomery	H. J. Till, M. D.
March 2	Birmingham	W. E. Lawrence, M. D.
March 3	Huntsville	B. B. Jordan, M. D.
March 4	Anniston	G. G. Woodruff, Jr., M. D.
March 5	Auburn-Opelika	Kenneth Strother, M. D.
March 6	Mobile	W. L. Sellers, M D.
March 7	Selma	Walter L. Green, Jr., M. D.
March 8	Tuscaloosa	J. S. Tarwater, M. D.
March 9	Florence	Howard C. Johnson, M. D.

Samples of educational material prepared by AMA were distributed at each meeting. These included: A fact sheet outlining principal features of the Eldercare program; a pamphlet entitled "Why Eldercare is the Best Answer to the Health Care Needs of the Elderly"; a pamphlet entitled "Why Pay Twice"; a reprint from the Reader's Digest issue of February, 1965, of an article by former U. S. Rep. Walter H. Judd, M. D., entitled "Medicare or Medical Care"; a question-and-answer pamphlet entitled "Why Eldercare Offers Better Care than Medicare."

Meetings usually were opened with the showing of a film distributed by AMA of Dr. Ward's address to the House of Delegates entitled "Can 200,000 Doctors Be Wrong?". When it was impossible to show the film, a recording of the speech was played.

(Following the series of meetings, a number of county societies arranged to have the film shown on television stations in their areas or had the recorded speech broadcast by local radio stations. The cost of these broadcasts was borne entirely by the county societies.)

Operation Eldercare was patterned closely along the lines of the 1963 campaign known as "Operation Hometown." Each county society was asked to organize several committees to implement the efforts of the State

(Continued on Page 794)



ECONOMY

When you prescribe or recommend Allbee with C, you can be sure your patient is getting a rational, specific multivitamin formulation at an economical price. The potent formula is sensible and simple. It contains therapeutic amounts of the water-soluble B and C vitamins. These vitamins are expended rapidly in the body and need to be replenished frequently. There are no extraneous factors, no frills in Allbee with C. It's the no-nonsense vitamin in the yellow and green capsule that always gives your patient his money's worth.

Each capsule contains: Thiamine mononitrate (B_1), 15 mg.; Riboflavin (B_2), 10 mg.; Pyridoxine hydrochloride (B_6), 5 mg.; Nicotinamide, 50 mg.; Calcium pantothenate, 10 mg.; Ascorbic acid (vitamin C), 300 mg.

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RICHMOND, VIRGINIA 23220

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ALLBEE® WITH C


THERE'S NOTHING
LIKE A VACATION*
FOR RELAXING
STRESS-INDUCED
SMOOTH MUSCLE
SPASM . . .

NOTHING, THAT IS,
EXCEPT THE SEDATIVE-ANTISPASMODIC
BENEFITS OF

DONNATAL®

There's nothing quite like a vacation to ease the pressures of the modern, "workingday" world. And for the patient who can't get away from it all, there's nothing quite like Donnatal to relax stress-induced smooth muscle spasm. For 31 years it has been the antispasmodic-sedative most often prescribed for relieving functional disturbances of tone and motility of the gastrointestinal tract.

belladonna alkaloids in optimally balanced ratio

In Donnatal, natural belladonna alkaloids are rationally balanced in a specific, fixed ratio that provides "the greatest efficacy with the smallest possible dose."[1] They avoid the clinical uncertainties of the variable tincture and extract of belladonna, and are considered superior in range of action to atropine alone.[2] Furthermore, they are generally recognized as being more effective than the synthetics for relieving visceral spasm.

phenobarbital for sedation

Years of clinical use have established phenobarbital as one of the most efficient and highly regarded sedatives. In fact, for general sedation it is the drug of choice.[3] In Donnatal, phenobarbital potentiates the spasmolytic effects of the belladonna alkaloids, lessening emotional tensions and checking the neurogenic impulses that trigger GI disorders.

more than 24 indications in PDR

Donnatal has withstood the test of time to become the classic sedative-antispasmodic because of its unsurpassed effectiveness, safety, economy, uniformity of composition, and dosage convenience. Its widespread acceptance and usage by the profession can also be attributed to its versatility in treating disorders characterized by smooth muscle spasm. There are more than two dozen distinct and separate indications for Donnatal listed in the current PDR.

IN EACH TABLET, CAPSULE, OR (5 cc.) OF ELIXIR

hyoscyamine sulfate	0.1037 mg.
atropine sulfate	0.0194 mg.
hyoscine hydrobromide	0.0065 mg.
phenobarbital	(1/4 gr.) 16.2 mg.

(warning: may be habit forming)

IN EACH EXTENTAB

hyoscyamine sulfate	0.3111 mg.
atropine sulfate	0.0582 mg.
hyoscine hydrobromide	0.0195 mg.
phenobarbital	(3/4 gr.) 48.6 mg.

(warning: may be habit forming)

BRIEF SUMMARY: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma, or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease, or a hypersensitivity to any of the ingredients.

REFERENCES: 1. Vollmer, H.: Arch. Neurol. and Psychiat., 43:1057, 1940. 2. Morrissey, J.H.: J. Urology, 57:635, 1947. 3. Krantz, J.C., Jr., and Carr, C.J.: Pharmacological Principles of Medical Practice, 2nd ed., Baltimore (1954), 552.

*This one at Westover, elegant Colonial Virginia plantation, located on the James River near Richmond. Built in the early 1730's by William Byrd II, founder of Richmond, it is now the home of Mrs. Bruce Crane Fisher.

A. H. ROBINS COMPANY, INC., RICHMOND, VA.

A·H·ROBINS

THE ELDERCARE CAMPAIGN

(Continued from Page 790)

Association. County society Presidents were requested to designate a co-ordinator of the various programs and in almost every instance the President assumed this important responsibility himself. He also was requested to appoint a publicity chairman to deal with local news media and keep them abreast of the constantly changing situation; to create a speaker's bureau composed of doctors who would volunteer to make speeches to civic clubs and other groups within their areas; a letter-writing committee to maintain a constant flow of letters to congressmen requesting them to stand firm in favor of the Eldercare program; and, a materials distribution committee (mostly composed of members of the Auxiliary) with responsibility for placing materials prepared by AMA and MASA in the proper hands.

With one or two exceptions, attendance at the regional meetings was widely representative of the county societies, and the final results proved valuable. Hundreds of physicians throughout Alabama were galvanized into action and much public support for the Eldercare plan was generated.

The central office prepared a suggested speech for use by volunteers in the speaker's bureaus, and letters were sent to all major civic clubs in Alabama informing them that representatives of their local medical societies were available to explain the Eldercare program.

Meanwhile, in the central office, six students of a Montgomery business school were employed on a part-time basis to package, address, and mail pamphlets and other informational matter to every physician in the State. Convenient order forms were enclosed, resulting in many re-orders.

A special page was inserted in the February, 1965, issue of the *Journal* inviting physicians to participate in the following ways:

(1) To make available to patients and friends literature prepared by AMA and MASA;

(2) To write a letter to his congressmen and ask his friends to do likewise;

(3) To make appearances before civic clubs, on radio or television, and before other organizations if requested by MASA; and

(4) To make a cash contribution to defray the cost of the program.

Hundreds of postal cards which had been printed on the page poured into the central office. Most of these offered to distribute literature and to write their congressmen. A sufficient number also volunteered to make speeches to meet the needs in every area of the State. Cash contributions totaled $255.

The demand for material from state headquarters was so heavy at one period that the Auxiliary of the Montgomery County Medical Society was asked to send volunteer workers, a request which was instantly and cheerfully met. While it is impossible to personally recognize every person who rendered service during the campaign, it is felt appropriate that a special vote of thanks is due these ladies who gave so unstintingly of their time and energies in the hour of need.

The five pamphlets and brochures distributed through the central office totaled approximately one and one-half million copies. Many physicians reordered some of the pamphlets several times.

To keep the program geared at peak speed, the central office subscribed to the Wide Area Telephone Service (WATS) at a cost of $500 per month for the duration of the campaign. This made possible instant contact with all officers and committeemen.

The central office, and physicians who were their personal friends, kept in frequent contact with the Alabama delegation in the Congress to keep them safely anchored to the cause of medicine.

The results of these efforts were apparent when the final vote on the measure came in the House of Representatives. Seven of the eight Alabama representatives voted consistently for Eldercare and against Medicare.

(Continued on Page 798)



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Tetracycline HCl-Antihistamine-Analgesic Compound

Each tablet contains:

ACHROMYCIN® Tetracycline HCl	125 mg	Caffeine	30 mg
Acetophenetidin (Phenacetin)	120 mg	Salicylamide	150 mg
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Effective in controlling complicating tetracycline-sensitive bacterial infection and providing symptomatic relief in allergic diseases of the upper respiratory tract. Possible side effects include drowsiness, slight gastric distress, anorexia, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation), photodynamic reaction to sunlight and increased intracranial pressure (in young infants). Contraindication: History of hypersensitivity to tetracycline. Average adult dosage: 2 tablets four times daily, given at least one hour before, or two hours after meals. Patient should avoid direct exposure to artificial or natural sunlight; and should not drive a car or operate machinery while on drug. Reduce dosage in impaired renal function. Stop drug immediately at the first sign of adverse reaction.

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"The main function of the carotid sinus is regulation of the blood pressure...."[1]

The veratrum component of Salutensin acts here (and in the myocardium), initiating "...a reflex fall in blood pressure through a generalized vasodilation and fall in heart rate."[2]



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This is a logical Blood Pressure Regulator

BECAUSE IT ENHANCES THE BODY'S OWN MECHANISMS FOR REDUCING BLOOD PRESSURE

In mild to moderate hypertension:

Salutensin enhances the body's own mechanisms for lowering blood pressure. The veratrum component of Salutensin acts on the carotid sinus and myocardial receptors, initiating "...a reflex fall in blood pressure through a generalized vasodilation and fall in heart rate."[2] To achieve this reflex modification of hypertension, Salutensin utilizes protoveratrine A. In addition, to facilitate and maintain blood pressure reduction, Salutensin incorporates reserpine and a highly effective thiazide. In general, side effects have been reported infrequently but may include those listed in the therapeutic summary.

Simple dosage—low-cost therapy: Many patients on Salutensin respond to 1 tablet *b.i.d.* Long-term economy is assured, since dosage can frequently be lowered after initial control is established.

Available: Prescription-size bottles of 60 tablets.

References: 1. Editorial: JAMA *191*:592 (Feb. 15) 1965. 2. Meilman, E., in Moyer, J.H.: Hypertension, Philadelphia, W.B. Saunders Company, 1959, p. 395.

BRISTOL THERAPEUTIC SUMMARY
For complete information consult Official Package Circular.
Indications: Essential hypertension.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs.
Contraindications: Salutensin is contraindicated in severe depression.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss, which may cause digitalis intoxication, responds to potassium-rich foods, potassium chloride or, if necessary, stopping therapy. Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy two weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution with patients with peptic ulcers or renal insufficiency (if severe, Salutensin is contraindicated).
Side Effects: Hydroflumethiazide: Purpura plus or minus thrombocytopenia, hyperuricemia, leukopenia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet *b.i.d.*

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Salutensin®

Each tablet contains: protoveratrine A, 0.2 mg.; hydroflumethiazide, 50 mg.; reserpine, 0.125 mg.

THE ELDERCARE CAMPAIGN

(Continued from Page 794)

In the Senate both Alabama senators voted in favor of Medicare.

Concurrently with the series of regional meetings a statewide newspaper-television campaign was planned. With funds available from AMA and MASA, an advertising budget of $6,000 was approved for television and newspaper advertising. It was planned to use 22 daily newspapers and 99 weekly newspapers at a cost of $3,100. The cost for television would have been $2,670 for two 60-second presentations on seven channels. Kimbrough Advertising Agency of Montgomery was contracted with to prepare and schedule the advertising. However, the program was never effected, primarily due to the constantly changing situation in Washington, with each change necessitating alteration of plans at the State level.

News reports and information received by the AMA Washington office and the U. S. Chambers of Commerce made it apparent that tremendous pressure was being brought to bear on the Congress from every State for modification of the King-Anderson bill. There were rumors, which later proved correct, that the House Ways and Means Committee was rewriting the bill to overcome major objections of organized medicine and other protesting groups.

It was this situation which prompted President Glenn to cancel the newspaper and television advertising until the situation could be clarified.

On February 14 and 15, 1965, the Associated Industries of Alabama held a meeting in Washington and invited MASA to send a delegation. President Glenn appointed Dr. John Hamilton, President of the Morgan County Medical Society, Dr. Robert Miller, and Dr. E. W. Stevenson to attend. While in Washington, the delegation conferred with Alabama congressmen and with members of the AMA Washington staff. A major result of the mission was an agreement from Rep. James Martin to co-sponsor the Eldercare plan, which had been introduced in the Congress as the Curtis-Herlong Bill (H. R. 3727).

The House Ways and Means Committee rewrote King-Anderson as H. R. 6675 and reported out the bill in early April. A rule was adopted that only one motion on the House floor was permissible to recommit. This motion failed by 23 votes, the narrow margin by which H. R. 6675 passed the House on April 8, 1965.

H. R. 6675 was a combination of three separate bills which included the Social Security tax features of the King-Anderson Bill (Title XVIII, Part A), the Byrnes Bill (Title XVIII, Part B), and the Eldercare Bill (Title XIX). AMA called the bill a three-layer cake, a compromise designed to placate all contending groups.

A few days later came the Annual Session of the Medical Association of the State of Alabama, and responsibility for continuing the fight passed to the incoming President, James G. Donald, M. D.

It was announced that public hearings on H. R. 6675 would be held by the Senate Finance Committee and that MASA was invited to present its views on May 11, 1965. The Association voted to send a delegation composed of President Donald, Drs. Paul Burleson of Birmingham and John Chenault of Decatur, members of the Board of Censors, and Judge Newton Powell of Decatur.

Dr. Chenault was designated spokesman and made a strong argument against provisions of the bill which imposed a heavy tax on the wage earners between the ages of 18 and 64, included the services of pathologists, radiologists, physiatrists and anesthesiologists as part of inpatient hospital services, called for administration of Part B by federal rather than State agencies, and included physicians in the social security system.

Notwithstanding these objections which also had been expressed by the AMA leadership and other State medical associations, H. R. 6675 was adopted by the Senate on July 9, 1965, and signed into law by the President on July 30, 1965.

The total amount of time and money ex-

pended in the Eldercare campaign in Alabama cannot be determined since so many physicians and others worked virtually around the clock during its progress. Thousands of letters and hundreds of telegrams and telephone calls went to members of Congress, paid for by individual physicians who never sought recompense. Hours were taken away from the practice of medicine to engage in the campaign, and the value of this is incalculable. Members of the Boards of Censors and Trustees and officers of the Association travelled countless miles to attend conferences and did not seek reimbursement for their expenses. One Vice President used his own funds for rental of a movie projector, the President of a county society made speeches to civic clubs far from his own home at his own expense.

While Medicare as embraced in the King-Anderson Bill did become the law of the land over the strong objections of organized medicine, some solace can be taken from the fact that it won by a slim 23-vote margin in the House and that seven out of eight Congressmen from Alabama were unwavering in their support for the physicians' Eldercare plan. There is ample evidence that at the time the final votes were taken, congressional support for Medicare was waning and that King-Anderson would have been defeated except for the landslide presidential victory of 1964 and the large number of labor-backed liberal Congressmen elected that year.

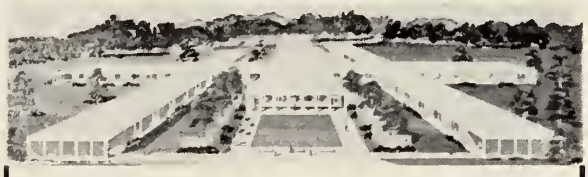
The solidarity exemplified by physicians in Alabama during the Eldercare campaign had one beneficial effect. With its ranks already closed, it enabled the Association Committee on Legislation to use this opportune time to accomplish a most effective State Legislative program which is now bringing additional millions to the State Department of Public Health for its varied programs. It is safe to say that the legislative accomplishments of 1965 would have been impossible without the solid phalanx physicians presented when vital matters were being deliberated in the State Legislature.

Teetotallers May Get Gout

At last the happy truth is out—
Port wine is NOT the cause of gout;
Far more responsible for pain are kidneys,
liver, sweetbreads and brain;
The Clubman may by any means avoid
Anchovies and sardines,
And citizens of every sort
Owe some apology to port!

A. P. Herbert
(Reprinted)

THE INTENSE BEAM OF THE LASER promises to become a useful, nearly painless tool for removing warts, horny growths and other noninflammatory skin lesions, according to Dr. Robert G. Wilson of the University of Cincinnati. Small lesions completely covered by the laser beam are totally destroyed, and peel off with a minimum of scarring. Tattoos can be removed with "most fascinating" results. With sharp focusing of the beam, the tattoo pigment can be successfully destroyed and the scar is acceptable cosmetically.—*Med. World News*, Dec. 31, p. 38.

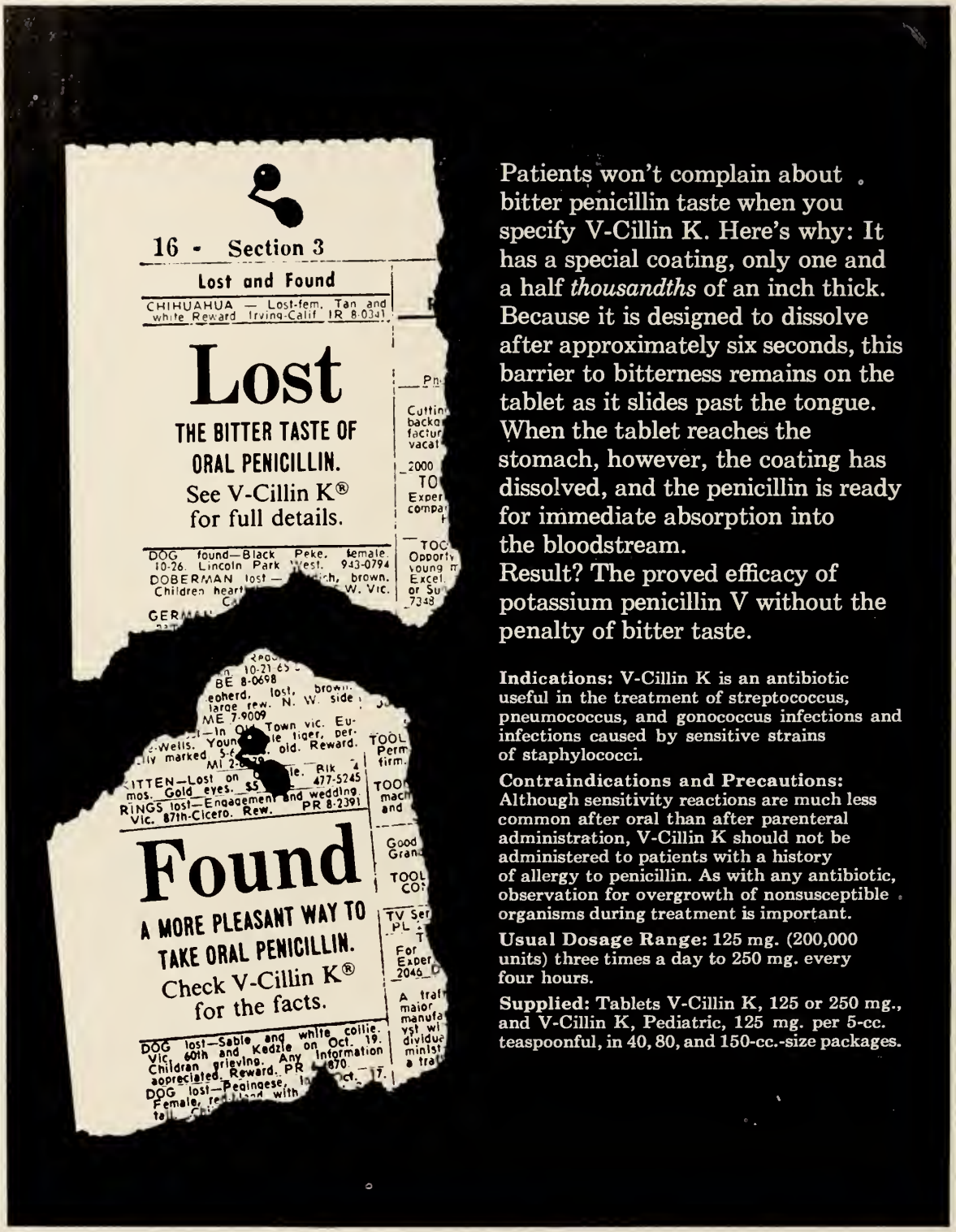


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Result? The proved efficacy of potassium penicillin V without the penalty of bitter taste.

Indications: V-Cillin K is an antibiotic useful in the treatment of streptococcus, pneumococcus, and gonococcus infections and infections caused by sensitive strains of staphylococci.

Contraindications and Precautions: Although sensitivity reactions are much less common after oral than after parenteral administration, V-Cillin K should not be administered to patients with a history of allergy to penicillin. As with any antibiotic, observation for overgrowth of nonsusceptible organisms during treatment is important.

Usual Dosage Range: 125 mg. (200,000 units) three times a day to 250 mg. every four hours.

Supplied: Tablets V-Cillin K, 125 or 250 mg., and V-Cillin K, Pediatric, 125 mg. per 5-cc. teaspoonful, in 40, 80, and 150-cc.-size packages.

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V-Cillin K®
Potassium Phenoxymethyl Penicillin

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana.
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THE JOURNAL

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Abdominal Aortic Aneurysms

L. S. McGee, Jr., M. D., F. A. C. S.

By 1960 the reports of numerous authors, Wright, Blakemore, Estes, Gliedman, and Kampmeir, had shown that untreated abdominal aortic aneurysms carried a very high mortality. Lord summarized these studies by stating, "Aneurysm of the abdominal aorta is a frequently lethal entity resulting in death from rupture within two years of discovery in at least one half of the patients afflicted." DeBakey and others have demonstrated that aneurysms can be resected with a low mortality if rupture has not occurred.

In 1962 Schatz, of the Mayo Clinic, reported on 141 cases of aneurysms which had not been operated upon. Of these, 114 patients were not offered surgical repair, and approximately 75 per cent of the aneurysms were described as small. These authors found a somewhat lower mortality, 13 per cent dead in one year and 48 per cent dead in three years. It is of interest that of those patients dying approximately 44 per cent died of ruptured aneurysms.

At about this time I was asked to see a 76 year old lady with an aneurysm 6.5 centimeters in diameter. She had had a high gastric resection for duodenal ulcer, had severe emphysema, and was in congestive heart failure. I advised this lady and her family that nothing should be done for her aneurysm. One week after discharge from the hospital this patient was brought in dead on arrival of a ruptured abdominal aortic aneurysm. This case led me to wonder what the fate of abdominal aortic aneurysms was in our area, Mobile and South Alabama.

There were 35 patients with abdominal aortic aneurysms admitted to private hospitals in Mobile for the four years, 1959 through 1962 (Table No. 1). There were seven

TABLE 1

ABDOMINAL ANEURYSMS 1959-1962

MOBILE INFIRMARY—
PROVIDENCE HOSPITAL

Aneurysms not resected alive 1963	7
Aneurysms not resected—dead other causes	6
Patients dying ruptured aneurysm	9
Patients surviving ruptured aneurysm	2
Unruptured aneurysms resected	11*
Total	35

patients not resected who were still alive in 1964. There were six patients who died of other causes during this period of time. Nine patients died of ruptured abdominal aortic aneurysms, and two patients survived a ruptured aneurysm. Eleven patients had their aneurysm resected electively. Two of these 11 were referred elsewhere for their surgery. While much information can be obtained from a detailed study of these aneurysm cases, I believe that the significant finding is that there were as many people in Mobile dying of ruptured abdominal aortic aneurysms in 1959 through 1962 as were operated upon electively. This would certainly seem to indicate that not enough patients in our

area were being brought to surgery for elective resection of their aneurysm. In the last two years the ratio of patients dying of ruptured aneurysms to those operated upon electively would be much lower, but I think the figures for as recent a period as 1959 through 1962 are quite impressive.

I would like to report on 18 patients with abdominal aortic aneurysms operated upon by me through 1964. There were 11 patients who had unruptured aneurysms operated upon electively (Table No. 2). Although

TABLE 2

UNRUPTURED ANEURYSMS RESECTED
1961-1964 (LSM)

Patient	Age	Alive	Dead	Morbidity
O. B.	63	1		None
D. S.	69	1		None
P. B.	66	1		Tips of 1st and 5th toe
R. R.	58	1		None
I. R.	56	1		Hypertension
B. E.	74	1		Cardiac arrest x 2
H. H.	66	1		None
R. D.	60	1		None
E. W.	57	1		None
N. S.	62	1		None
S. G.	66	1		None
	Total	11	0	

there were rather trying times with several of these patients they all survived their surgery without any significant disability. All the patients in this group are still alive and well with the exception of the first patient who died as he entered the emergency room three years postoperatively. Ironically, he had exsanguinated from a small low lying rectal polyp.

There were seven patients with ruptured aneurysms operated upon by me during this same period of time (Table No. 3). Three of these died. The high mortality, just under 50 per cent, shows the importance of operating on aneurysms as an elective procedure rather than as an emergency one.

I would like now to discuss our indications for surgery and comment briefly on a few technical details. Patients with aneurysms seven centimeters or larger in diameter or whose aneurysms are symptomatic should have surgery. In patients who have aneurysms seven to five centimeters wide, surgery probably should be recommended unless

TABLE 3

RUPTURED ANEURYSMS RESECTED
1961-1964 (LSM)

Patient	Age	Alive	Dead	Morbidity
S. H.	70		1	
S. M.	25	1		None
K. D.	69	1		None
F. W.	58		1	
C. B.	60	1		None
P. O.	60	1		None
L. T.	86		1	
	Total	4	3	

there are serious medical contraindications. If the aorta is five centimeters or less in diameter the patient can probably be observed unless there are symptoms suggesting acute dilatation or imminent rupture.

The diagnosis of aneurysm is usually either through palpation or by X-ray, the intravenous pyelogram being the X-ray that most commonly detects the presence of an aneurysm. There is little, if any, indication for aortography in the preoperative workup. This is not necessary for the diagnosis and an aortogram gives a distorted picture as to the size of an aneurysm. The cause of this is rather obvious to anyone who has seen the thick laminated clot which lines the inside of an aneurysm.

The patients are operated on through a long midline incision. Small aneurysms are excised in toto, but in large aneurysms cross clamping is effected above and below and the aneurysm entered anteriorly. After all laminated clot and atheromatous intima has been removed the aneurysm is resected down to the retroperitoneal structures. Hemostasis is obtained by suturing the bleeding lumbar

arteries. This technique prevents the troublesome problem with attempting to dissect the posterior wall of the aneurysm off the vena cava and other retroperitoneal structures. I have used woven Teflon grafts for restoration of continuity of the aorta, and have used silk cardiovascular suture. For any occlusive disease problem knitted Dacron is a preferable synthetic material and this may well be true for aneurysms. Dacron or one of the other newer suture materials may be preferable to silk sutures. The patient should be hydrated with a liter of five per cent dextrose or Ringer's Lactate just prior to surgery. Mannitol is not used routinely but only in those patients demonstrating postoperative oliguria. We have not had any significant problem with renal shutdown since using the preoperative hydration and adequately heparinizing the distal arterial segments during cross clamping. I would think that aneurysm is an area where preoperative antibiotics are indicated.

The diagnosis of ruptured aneurysm is somewhat more difficult than generally appreciated and primarily one of suspicion. Any patient who has an aneurysm and who is having abdominal, flank, or groin pain has a ruptured aneurysm until proven otherwise. Many will present in profound shock, others with no hypotension. In most cases one can palpate the massive pulsating retroperitoneal hematoma, even in the obese. A study that is completely unreliable is the hemoglobin or hematocrit, due to the relative hemoconcentration produced by retroperitoneal edema and other causes of intravascular water loss. Once the diagnosis is made all haste should be made to get the patient to the operating room. There is some question as to whether or not to transfuse the patient while he is being readied for surgery; the fear being that one may precipitate the dislodgement of a clot when the blood volume is raised. Probably a middle of the road course is best with transfusion of blood, but not any massive replacement by pumping. When the patient is in the operating room and massive transfusion is given as the case proceeds, it is most important that the blood be warm. In these patients with massive blood replacement frequently cardiac arrest is caused by large amounts of cold citrated blood with a high potassium concentration. When the peritoneal cavity is opened, in most cases a clamp can be applied above the aneurysm and below the renal arteries by blunt dissection. Very rarely will it be necessary to occlude the aorta at the aortic hiatus. Almost never is it necessary to do a thoracotomy as has been suggested by some authors. In the patient with a ruptured aneurysm I feel that the use of Mannitol to stimulate diuresis is quite important both during the operative procedure and in the postoperative phase. Ruptured abdominal aortic aneurysm is certainly a formidable disease entity, and one that taxes the skill of any surgeon.

Summary

In Mobile, Alabama during a recent four year period there were as many patients dying of ruptured abdominal aneurysms as had their aneurysm resected electively. A series of cases has been presented demonstrating that aneurysms can be operated on with little mortality or morbidity if they are seen before rupture occurs.

Addendum

In 1965 there have been 12 aneurysms operated on by the author; ten of these were not ruptured. There were two deaths, one in a 39 year old man with a tremendous aneurysm and diffuse vascular disease who died six days postoperatively of a cerebral hemorrhage. The second death occurred in a 77 year old man on the fifth postoperative day, due to a sudden cardiac arrhythmia. Of the two ruptured aneurysms one 86 year old man survived, and a 76 year old man expired.

(Bibliography on next page)

Bibliography

1. DeBakey, Michael E., M. D.; Crawford, E. Stanley, M. D.; Cooley, Denton A., M. D.; Morris, George C., Jr., M. D.; Royster, Thomas S., M. D.; Abbott, Walter P., Ph. D.: "Aneurysm of Abdominal Aorta: Analysis of Results of Graft Replacement Therapy One to Eleven Years After Operation," Ann. Surg., 160: 622-639 (Oct.) 1964.

2. Estes, J. E., Jr.: "Abdominal Aortic Aneurysm: Study of One Hundred and Two Cases," Circulation 2: 258-264 (Feb.) 1950.

3. Gliedman, M. L.; Ayers, W. B.; and Vestal, B. L.: "Aneurysms of Abdominal Aorta and Its Branches," Ann. Surg., 146: 207-217 (Aug.) 1957.

4. Kampmeir, R. H.: "Aneurysm of the Abdominal Aorta: A Study of Seventy-three Cases," Am. J. Med. Sci., 192: 97, 1936.

5. Schatz, I. J.; Fairbairn, J. F.; and Juergens, J. L.: "Abdominal Aortic Aneurysms: Reappraisal," Circulation 26: 200-205 (Aug.) 1962.

6. Wright, I. S.; Urdaneta, E.; and Wright, B.: "Reopening Case of Abdominal Aortic Aneurysm," Circulation 13: 754-768 (May) 1956.

Women Outlive Men After Cancer Surgery

Scientists at the National Cancer Institute, National Institutes of Health have confirmed an earlier finding that, among patients operated on for lung cancer, women live longer than men. In their study of 504 women and 511 men, the Public Health Service statisticians also identified several factors that help to explain this sex difference in survival rates: the type of tumor, extent of disease, and amount of surgery performed.

A marked difference was found between male and female patients in respect to tumor type, with adenocarcinomas and alveolar cell tumors occurring about 3 times more frequently in women than in men. Among patients with these types of tumors, survival rates were substantially higher for women, while among patients with epidermoid carcinoma—the most common type of lung cancer in men—survival rates in men and women were about the same. Among both men and women with adenocarcinomas or alveolar cell tumors, 3 of every 4 had growths confined to one lobe; while among patients with epidermoid carcinomas, women were more likely than men to have a tumor of limited extent.

The more frequent occurrence of adenocarcinomas and alveolar cell tumors in women, and the more frequent occurrence of tumors limited to one lobe account for the fact that, among surgically treated patients, almost one-half of the women, compared to one-fourth of the men, had only part of the lung removed (a lobectomy). However, among all patients with localized disease treated by lobectomy, the outlook remained substantially more favorable for women than men. Thus, part of the survival advantage in favor of women remains unexplained by the present study which was reported in the February issue of the *Journal of the National Cancer Institute* by Roger R. Connelly, Dr. Sidney J. Cutler, and Paula Baylis of the Institute's Biometry Branch.

Neurovascular Compression Syndrome Of The Upper Extremity

Charles L. Cox, Jr., M. D., F. A. C. S.

Neurovascular compression syndrome of the upper extremity embraces a number of complex afflictions involving the upper extremity and neck. These are characterized by symptoms of pain, numbness, and paresthesia, with or without changes in the vascular supply to the arm. With the current interest in vascular surgery, most recent articles have tended to emphasize the dramatic, but somewhat uncommon, vascular complications of poststenotic dilatation or aneurysm of the subclavian artery, or organic vascular occlusive disease secondary to thrombosis or emboli. However, in clinical practice, most symptoms are related to the effects of chronic intermittent pressure neuropathy due to pressure or stretching of the nerves, somewhere along their peripheral course, beginning at the spinal canal and extending to the distal nerve. Well described clinical entities include the cervical rib syndrome, the scalenus anticus syndrome, the costoclavicular syndrome, the hyperabduction syndrome or pectoralis minor syndrome, tardy ulnar nerve palsy, and the carpal tunnel syndrome. In addition, nerve root pressure secondary to discogenic disease, hypertrophic arthritis, narrowing of the intervertebral foramina or post-traumatic neuropathy are also encountered.

Current concepts of the nature of the basic problem in the base of the neck have been unduly influenced by the search for objective evidence of abnormality in the upper extremity. There has been undue emphasis of the importance of the various "stretch tests" of the neck and of objective neurological deficiency. This lack of reliable objective testing has led to much confusion. Vascular compression is not necessarily demonstrable and neurologic deficits may be transient and poorly defined objectively. Many of the patients reported have been labeled psychoneurotics for variable periods of time before they came to proper management.

Law, in 1920, performed the first elective scalenotomy for the cervical rib syndrome. Adson, in 1927, focused attention on the soft structures of the neck as the cause of the "cervical rib syndrome" and since that time these structures in the base of the neck have been widely incriminated. The "Adson's Test" is an important diagnostic procedure and is still employed in establishing a diagnosis of the "scalenus anticus syndrome." However, it has been repeatedly demonstrated that a significant number of normal people will demonstrate this positive test. Also, scalenotomy will not uniformly result in a negative test postoperatively, even in patients with good subjective relief of symptoms after surgery.

The purpose of this presentation is to review impressions gained over the past five years with 40 patients who have been subjected to anterior scalenotomy.

Symptoms

The usual presenting symptom is pain and paresthesia with numbness and occasional blanching of the hand. Most patients are women between the ages of 20 and 60 years. There is an occasional complaint of rest pain and paresthesia, but usually there is an association of symptoms with physical activity involving working above the head or doing the usual household chores of sweeping, ironing, and carrying bundles. It is interesting that women frequently complain of inability to put up their hair because of numbness and lack of proprioceptive sense in the fingers. In addition to brachial plexus neuritis or neuropathy, a substantial number of patients also complain of pain in the posterior neck, occipital headaches, and other discomfort in the distribution of the lower segment of the cervical plexus. The nuchal and occipital pain is frequently a presenting complaint, and the shoulder and hand problems are sometimes only mentioned after direct questioning on that point. In very few cases is valid vascular symptomatology a prominent complaint and only rarely is Raynaud's phenomenon noted. Subjective muscular weakness is frequently mentioned but has not been substantiated by objective testing. The distribution of neurological symptoms occasionally coincides with the ulnar nerve distribution, but more frequently was segmental, involving the upper trunks of the brachial plexus. A history of paresthesia on awakening is often elicited. However, this is quite frequent in normal patients with no other evidence of abnormality and is not considered a prominent part of this syndrome. The average patient had had symptoms for approximately two to three years. It is not unusual, however, to date the slow progression over a period of ten to 15 years. Two patients in this group had acute paresthesia and hypesthesia following shoulder trauma, both of whom had cervical ribs on the involved side.

Anatomical Considerations

The subclavian artery emerges from the thorax by passing between the scalenus anticus and scalenus medius muscles. It is accompanied over the first rib by the brachial plexus. Therefore, both artery and the brachial plexus are found in a triangle formed by the first rib and the tendinous lower portions of the scalenus anticus and medius muscles. The degree of fibrous band component associated with the lower portion of the muscles varies, and there exists, at times, firm fibrous bands which may sharply define the posterior border of the scalenus anticus and the anterior border of the scalenus medius muscle. The angle of the first rib influences the size of this space. The tendinous insertion of the scalenus medius makes the posterior and inferior border of the narrow triangular space relatively rigid. Because of this attachment, it is unusual to note any change in position of the first rib following anterior scalenotomy. At surgery the neurovascular bundle slides anteriorly and inferiorly, after removal of the insertion of the scalenus anticus, assuming a lower position over the first rib, thus creating an illusion of movement of the rib. This relieves the stretch of the brachial plexus.

The scalenus anticus muscle arises from the anterior intertubercular groove and the anterior surface of the posterior tubercles of the transverse process of vertebra C3 to C6. The fibers of origin usually fuse with the muscle belly but occasionally those from C6 vertebra may pass behind the subclavian artery. Also, the roots of the brachial plexus have been found to emerge through the muscle substance in as many as 39 per cent of the cases. The origin of the posterior components of the scalenus anticus are therefore capable of compressing the roots of the C3 to the C7 segments as they emerge from the intervertebral foramina. The cervical plexus is formed by the anterior rami of the first four cervical nerves, the lower segments of

which can be affected. These anatomic variations can account for symptoms of neuritis outside of the peripheral distribution of the nerve fibers passing through the classical "scalenus anticus syndrome" triangle in the base of the neck. Traction and pressure on these nerve roots are in fact a prominent feature of a large percentage of cases and also account for some of the confusing symptom complexes.

Diagnosis

Objective testing as an aid in establishing a diagnosis has been disappointing. Such objective testing can be divided into tests for vascular compression, neurological deficits, or radiographic evidence of disease. None of these has proved to be a reliable guide in selecting patients for surgery. A study was, therefore, undertaken to re-evaluate the reliability of well established tests. For purposes of this study, each patient was evaluated by the surgical staff and by the physiotherapy department, the technician being trained in the performance of the various tests. This was done to assure as complete objectivity as possible. Oscillimetric studies, as well as palpation of the radial pulse, were done on both arms in all patients whether their symptoms were unilateral or bilateral. A neurological examination was performed on each patient. X-ray studies consisted of AP, lateral, and oblique views of the cervical spine, internal and external rotation films of both humeri and films of the clavicle. Modification of the "Adson's test" were performed with the arm adducted, with the arm at 90° abduction, and with the neck turned toward the same side, and toward the opposite side. Radial pulses were studied with both arms hyper-abducted and also with the shoulders hyperextended. Additional readings were obtained with direct pressure over the scalenus anticus muscle at the base of the neck. Each position was held for approximately one minute and the patient queried as to subjective paresthesia or pain. This was recorded along with the objective findings.

There were differences in the objective observations by various examiners and there was little correlation between the preoperative objective findings and subjective operative result. Objective neurological evaluation was disappointing and inconsistent. X-ray studies revealed an occasional cervical arthritis, narrowed disc, or small intervertebral foramina. A cervical rib or an enlarged transverse process of the seventh cervical vertebrae was occasionally encountered. All patients in this series were subjected to an anterior scalenotomy if subjective symptomatology could be reproduced by any of the preoperative tests. This was felt to be more reliable than any of the objective tests in evaluating a patient for surgery.

I would like to emphasize that none of the objective testing was considered as reliable as the production of subjective symptoms by the various tests. No one test seemed more likely to precipitate symptoms than any other test. As we gained experience, there was a tendency to rely upon simple pressure over the anterior scalene muscle which would produce a decrease in the radial pulse and produce subjective symptoms. This admittedly could be due to a high riding subclavian artery or to pressure over the brachial plexus itself. However, the mechanism was felt to represent the effects of stretching of the scalenus muscle fibers and brachial plexus.

Differential Diagnosis

The differential diagnosis includes a variety of conditions which can produce nerve compression anywhere from the spinal roots to the peripheral nerves. Causes of peripheral neuritis, as well as, vascular abnormalities, and referred pain from the diaphragm, heart, or biliary tract must be considered. A partial list of these conditions is presented in Table One. Further consideration of differential diagnosis of these various conditions is beyond the scope of this paper.

TABLE ONE

SOME CAUSES OF CHRONIC SHOULDER, ARM, OR HAND PAIN

1. Vascular lesions
 a. Scalenus anticus syndrome
 b. Cervical rib syndrome
 c. Hyperabduction syndrome
 d. Costoclavicular syndrome
 e. Arterial thrombosis
 f. Arterial emboli
 g. Aneurysm
 h. Raynaud's disease
 i. Thrombangiitis obliterans
 j. Vibrating tool (percussion) syndromes
 k. Reflex neurovascular dystrophy
 l. Obliterative atherosclerotic disease of terminal arteries

2. Nerve Lesions
 a. Cervical disc (herniated)
 b. Spinal cord tumor
 c. Superior sulcus tumor
 d. Neoplasm of brachial plexus (as in neurofibromatosis)
 e. Peripheral neuritis
 f. Traumatic injury to brachial plexus
 g. Causalgia
 h. Carpal tunnel syndrome
 i. Tardy ulnar palsy
 j. Reflex sympathetic dystrophy

3. Miscellaneous
 a. Cervical osteoarthritis
 b. Bursitis
 c. Referred pain from the diaphragm, heart or biliary tract

Treatment

Many people have transient paresthesia and numbness involving the upper extremity. Frequently these symptoms are related to an abnormal posture while sleeping or to other postural causes. They occur infrequently, last only for a few moments, and are of little or no significance. These patients should be treated with reassurance. However, if symptomatology recurs frequently to such a degree as to interfere significantly with the use of the upper extremity, additional measures are then in order. For mild insignificant recurring numbness and paresthesia, patients should be advised concerning posture and sleeping habits. Exercises designed to strengthen the elevators of the shoulders are of value. Only if a patient is having significant symptoms should a scalenotomy be considered. Milder symptoms will frequently respond to conservative measures and reassurance.

Surgery consists of transverse anterior scalenotomy, incising the fibrous insertion of the scalenus anticus muscle on the first rib. Following transection, the muscle fibers retract approximately 4 cm. In our experience, it was not necessary to remove a section of muscle. However, care should be taken to transect all muscular and fibrous bands anterior to the subclavian artery. The thyrocervical trunk conveniently marks the medial margin of the dissection. A cervical rib, if present, should be removed if it impinges upon the brachial plexus. If the scalenus anticus muscle is sectioned in its muscular belly, regeneration may occur. One patient who had been operated at another hospital, had received an excellent result from scalenotomy for three weeks, at which time symptoms recurred with increased severity. The neck was re-explored. Reattachment of the end of the muscle by scar tissue was noted. Following removal of the scalenus anticus from the first rib, she was again asymptomatic except for minor causalgia attributed to scarring around the brachial plexus produced by the initial procedure. Care should be taken to avoid unnecessary manipulation of the brachial plexus or dissection in the region of the brachial plexus which may produce postoperative cicatricial brachial neuropathy.

Results of anterior scalenotomy were good to excellent in over 95 per cent of the patients treated. Many had previously received a variety of treatments including neck traction, neck braces, physiotherapy, and psychotherapy. Two cases are presented:

Case Number One

A 45 year old female presented with symptoms of numbness, paresthesia, and pain radiating from the left shoulder to the forearm of several years duration. The pain was aggravated by lifting, working with her arms over her head, sweeping, and other household chores. Physical examination was negative except for a positive Adson's test on the involved side. A routine chest film failed to reveal evidence of a cervical rib. An anterior scalenotomy promptly relieved her pain, paresthesia, and numbness. She returned six months later having developed identical symptomatology in the other arm. Additional studies were done at that time including AP, lateral, and oblique cervical spine X-rays revealed marked narrowing of C5 and C6 interspace with osteoarthritic changes and lipping associated with narrowed intervertebral foramina. She was treated conservatively with traction and a "Four Poster" neck brace with some relief. She was insistent, however, that the symptoms in her right arm were identical with those which we had relieved with scalenotomy in her left arm. She was lost to follow up because her husband's job required transfer to another city.

Case Number Two

A 35 year old white male had been involved in an automobile accident approximately ten years prior to admission, sustaining injuries involving his neck. He had X-ray evidence of traumatic arthritis with narrowing of the C5 and C6 interspace with marked osteoarthritic lipping. His symptomatology consisted primarily of pain and paresthesia radiating from the posterior neck to his forearm and into the occipital region. Preoperative evaluation was essentially negative except for the subjective production of symptoms by the Allen test (abduction of the involved arm to 90° with the neck rotated to the opposite side.) An anterior scalenotomy gave marked relief of symptoms. He continued to have an occasional ache and pain and occasional paresthesia but was able to discard the neck brace which he had worn for 10 years.

Many patients with posterior neck and shoulder symptomatology and with occipital headaches, either as a primary complaint or associated with the typical symptomatology in the upper extremity, responded to anterior scalenotomy. It is postulated that these results are due to relief of pressure at the intervertebral foramina secondary to retraction and atrophy of the fibers of origin of the scalenus anticus muscle.

Conclusions

A number of phenomena may be involved in the production of symptoms involving the area of distribution of the brachial and cervical plexus. Nerve pressure at any point from the spinal cord to the peripheral nerve endings may produce significant symptoms. The subclavian artery may be compressed as it passes through the scalene triangle with the brachial plexus. Adverse results of compression of the subclavian artery are not as frequent as those of compression of the brachial plexus.

The various stretch tests are unreliable as an indication of operability and provide only indirect evidence of nerve pressure at the base of the neck. Because of the anatomic variations of the origin of the scalenus anticus muscle, it is postulated that at least some of these symptoms may be produced by pressure on the nerve roots as they emerge through the intervertebral foramina secondary to encroachment upon these spaces by the posterior fibers of origin of the muscle. Subjective symptoms produced by the various stretch tests may in part be due to this phenomena. The objective tests are of little value in preoperative evaluation. The excellent postoperative results can be accounted for on the basis of retraction and atrophy of the muscle fibers of the scalenus anticus muscle, relieving pressure at the base of the neck, as well as at the level of the intervertebral foramina. This also would account for the re-

lief of symptoms involving those nerve segments which do not pass through the "scalenus triangle" in the base of the neck. In addition, this would account for relief of symptoms in the two patients with cervical arthritis and/or cervical discs. The operative procedure is relatively simple and with little risk. In doubtful cases scalenotomy can be applied as a diagnostic test. X-ray evidence of osteoarthritis or narrowing of the disc space should not be a contraindication for scalenotomy if other factors suggest the presence of this syndrome.

References

1. Adson, Alfred W. Lewis, Surgical treatment for symptoms produced by cervical ribs and the scalenus anticus muscle. Practice of Surgery, Volume III, Chapter 14.

2. H. H. G. Eastcott, Reconstruction of the subclavian artery for complications of cervical-rib and thoracic-outlet syndrome. Lancet, 2: 1243 (December) 1962.

3. Hardy, James D., Arterial lesions of the upper extremity: A clinical review with illustrative cases. Am. Surgeon, 26: 525 (August) 1960.

4. Hardy, James D., Surgery of the aorta and its branches. Diseases involving the arterial supply to the upper extremities. American Practitioner and Digest of Treatment, 11: 231 (March) 1960.

5. Knoblauch, H., Results of surgical treatment of the scalenus syndrome. Der Chirurg, 28: 292 (July) 1957.

6. Lawson, John D. and Santos, George C., The lagging pulse sign. An aid in the diagnosis of the cervicobrachial neurovascular compression syndromes. American Journal of the Medical Sciences, 242: 673 (December) 1961.

7. Nelson, Paul A., Treatment of patients with cervicodorsal outlet syndrome. Journal of the American Medical Association, 163: 1570 (April) 1957.

8. Riddell, Douglas H., Kirtley, James A., Jr., Moore, James L. and Goduco, Roberto S.: Scalenus anticus symptoms. Evaluation and Surgical Treatment, Surgery, 47: 115 (January) 1960.

9. Stowell, Averill, Diagnosis and treatment of neck-shoulder-arm syndromes with medicolegal considerations. American Surgeon, 25: 59 (January) 1959.

10. Upmalis, I. H., S. G. & O., The scalenus anticus and related syndromes, (Int. Abst. Surg.) 107: 521 (December) 1958.

A NEW ROLE FOR FLUORIDES

The spaceman and the person suffering from various types of bone disease have a problem in common. The spaceman needs special protection of skeletal tissues during the periods of immobilization and weightlessness in prolonged space travel. Similarly, protection is needed for the person who experiences loss of the solid stuff of bone in illness or in severe localized jawbone destruction. A solution for the problem is indicated in new evidence for human tolerance of fluorides, chemicals which have great potential in preventive therapy against bone disease. Findings to date indicate that cells, tissues, and organs can tolerate fluoride concentrations above those that can reach body fluids through oral intake. Dosages of fluoride above the one part per million level recommended for prevention of tooth decay may be the answer for protection against losses of bony tissues from the skeletal and dental structures which may occur in illness, during immobilization in space, and in bone diseases. (R. F. Sognnaes: "Fluoride protection of bones and teeth," *Science*, 19 November 1965).

The Passion of Christ from a Medical Point of View

C. Truman Davis, M. D., M. S.

In this paper, I shall discuss some of the physical aspects of the passion, or suffering, of Jesus Christ. We shall follow Him from Gethsemane, through His trial, His scourging, His path along the Via Dolorosa, to His last dying hours on the cross.

I became interested in this about a year ago when I read an account of the crucifixion in Jim Bishop's book, The Day Christ Died. I suddenly realized that I had taken the Crucifixion more or less for granted all these years—that I had grown callous to its horror by a too easy familiarity with the grim details—and a too distant friendship with Him. It finally occurred to me that as a physician I didn't even know the actual immediate cause of death. The Gospel writers don't help us very much on this point, because crucifixion and scourging were so common during their lifetime that they undoubtedly considered a detailed description totally superfluous—so we have the concise words of the Evangelists: "Pilate, having scourged Jesus, delivered Him to them to be crucified—and they crucified Him."

I am indebted to many who have studied this subject in the past, and especially to a contemporary colleague, Dr. Pierre Barbet, a French surgeon who has done exhaustive historical and experimental research and has written extensively on the subject.

The infinite psychic and spiritual suffering of the Incarnate God in atonement for the sins of fallen man I have no competence to discuss; however, the physiological and anatomical aspects of our Lord's passion we can examine in some detail . . . what did the body of Jesus of Nazareth actually endure during those hours of torture?

This led me first to a study of the practice of crucifixion itself; that is, the torture and execution of a person by fixation to a cross. Apparently, the first known practice of crucifixion was by the Persians. Alexander and his generals brought it back to the Mediterranean world—to Egypt and to Carthage. The Romans apparently learned the practice from the Carthaginians and (as with almost everything the Romans did) rapidly developed a very high degree of efficiency and skill in carrying it out. A number of Roman authors (Livy, Cicero, Tacitus) comment on it. Several innoventions and modifications are described in the ancient literature; I'll mention only a few which may have some bearing here. The upright portion of the cross (or stipes) could have the cross-arm (or patibulum) attached two or three feet below its top—this is what we commonly think of today as the classical form, of the cross (the one which we have later named the Latin cross); however, the common form used in our Lord's day was the Tau cross (shaped like the Greek letter Tau or like our T). In this cross the patibulum was placed in a notch at the top of the stipes. There is fairly overwhelming archeological evidence

Dr. Davis is an ophthalmologist in private practice in Mesa, Arizona. He is a lay reader in the Episcopal Church.

The study of the Crucifixion is a portion of a manuscript on medicine and the Bible which is now in preparation for publication. The artifacts shown in the illustration are replicas prepared from archeological and Biblical data.

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that it was on this type of cross that Jesus was crucified.

The upright post, or stipes, was generally permanently fixed in the ground at the site of execution and the condemned man was forced to carry the patibulum, apparently weighing about 110 pounds, from the prison to the place of execution. Without any historical or biblical proof, medieval and Renaissance painters have given us our picture of Christ carrying the entire cross. Many of these painters and most of the sculptors of crucifixes today show the nails through the palms. Roman historical accounts and experimental work have shown that the nails were driven between the small bones of the wrists and not through the palms. Nails driven through the palms will strip out between the fingers when they support the weight of a human body. The misconception may have come about through a misunderstanding of Jesus' words to Thomas, "Observe my hands." Anatomists, both modern and ancient, have always considered the wrists as part of the hand.

A titulus, or small sign, stating the victim's crime was usually carried at the front of the procession and later nailed to the cross above the head. This sign with its staff nailed to the top of the cross would have given it somewhat the characteristic form of the Latin cross.

The physical passion of the Christ begins in Gethsemane. Of the many aspects of this initial suffering, I shall only discuss the one of physiological interest; the bloody sweat. It is interesting that the physician of the group, St. Luke, is the only one to mention this. He says, "And being in agony, He prayed the longer. And his sweat became as drops of blood, trickling down upon the ground."

Every attempt imaginable has been used by modern scholars to explain away this phase, apparently under the mistaken impression that this just doesn't happen.

A great deal of effort could be saved by consulting the medical literature. Though very rare, the phenomenon of Hematidrosis, or bloody sweat, is well documented. Under great emotional stress, tiny capillaries in the sweat glands can break, thus mixing blood with sweat. This process alone could have produced marked weakness and possible shock.

We shall move rapidly through the betrayal and arrest; I must stress again that important portions of the Passion story are missing from this account. This may be frustrating to you, but in order to adhere to our purpose of discussing only the purely physical aspects of the Passion, this is necessary. After the arrest in the middle of the night, Jesus was brought before the Sanhedrin and Caiphas, the High Priest; it is here that the first physical trauma was inflicted. A soldier struck Jesus across the face for remaining silent when questioned by Caiphas. The palace guards then blindfolded Him and mockingly taunted Him to identify them as they each passed by, spat on Him, and struck Him in the face.

In the early morning, Jesus, battered and bruised, dehydrated, and exhausted from a sleepless night, is taken across Jerusalem to the Praetorium of the Fortress Antonia, the seat of government of the Procurator of Judea, Pontius Pilate. You are, of course, familiar with Pilate's action in attempting to pass responsibility to Herod Antipas, the Tetrarch of Judea. Jesus apparently suffered no physical mistreatment at the hands of Herod and was returned to Pilate. It was then, in response to the cries of the mob, that Pilate ordered Bar-Abbas released and condemned Jesus to scourging and crucifixion. There is much disagreement among authorities about scourging as a prelude to crucifixion. Most Roman writers from this period do not associate the two. Many scholars believe that Pilate originally ordered Jesus scourged as his full punishment and that the death sentence by crucifixion came only in response to the taunt by the mob that the Procurator was not properly defending Caesar against this pretender who claimed to be the King of the Jews.

Preparations for the scourging are carried out. The prisoner is stripped of His clothing and His hands tied to a post above His head. It is doubtful whether the Romans made any attempt to follow the Jewish law in this matter of scourging. The Jews had an ancient law prohibiting more than forty lashes. The Pharisees, always making sure that the law was strictly kept, insisted that only thirty-nine lashes be given. (In case of a miscount, they were sure of remaining within the law.) The Roman legionnaire steps forward with the flagrum (or flagellum) in his hand. This is a short whip consisting of several heavy, leather thongs with two small balls of lead attached near the ends of each. (Figure 1.) The heavy whip is brought down with full force again and again across Jesus' shoulders, back and legs. At first the heavy thongs cut through the skin only. Then, as the blows continue, they cut deeper into the subcutaneous tissues, producing first an oozing of blood from the capillaries and veins of the skin, and finally spurting arterial bleeding from vessels in the underlying muscles. The small balls of lead first produce large, deep bruises which are broken open by subsequent blows. Finally the skin of the back is hanging in long ribbons and the entire area is an unrecognizable mass of torn, bleeding tissue. When it is determined by the centurian in charge that the prisoner is near death, the beating is finally stopped.



Figure 1



Figure 2

The half-fainting Jesus is then untied and allowed to slump to the stone pavement, wet with His own blood. The Roman soldiers see a great joke in this provincial Jew claiming to be a king. They throw a robe across His shoulders and place a stick in His hand for a scepter. They still need a crown to make their travesty complete. A small bundle of flexible branches covered with long thorns (commonly used for firewood) are plaited into the shape of a crown and this is pressed into His scalp. (Figure 2.) Again there is copious bleeding (the scalp being one of the most vascular areas of the body.) After mocking Him and striking Him across the face, the soldiers take the stick from His hand and strike Him across the head, driving the thorns deeper into His scalp. Finally, they tire of their sadistic sport and the robe is torn from His back. This had already become adherent to the clots of blood and serum in

the wounds, and its removal, just as in the careless removal of a surgical bandage, causes excruciating pain . . . Almost as though He were again being whipped—and the wounds again begin to bleed.

In deference to Jewish custom, the Romans return His garments. The heavy patibulum of the cross is tied across His shoulders, and the procession of the condemned Christ, two thieves and the execution detail of Roman soldiers, headed by a centurian, begins its slow journey along the Via Dolorosa. In spite of His efforts to walk erect, the weight of the heavy wooden beam, together with the shock produced by copious blood loss, is too much. He stumbles and falls. The rough wood of the beam gouges into the lacerated skin and muscles of the shoulders. He tries to rise, but human muscles have been pushed beyond their endurance. The centurian, anxious to get on with the crucifixion, selects a stalwart North African onlooker, Simon of Cyrene, to carry the cross. Jesus follows, still bleeding and sweating the cold, clammy sweat of shock. The 650 yard journey from the fortress Antonia to Golgotha is finally completed. The prisoner is again stripped of His clothes—except for a loin cloth which is allowed the Jews.

The crucifixion begins. Jesus is offered wine mixed with Myrrh, a mild analgesic mixture. He refuses to drink. Simon is ordered to place the patibulum on the ground and Jesus is quickly thrown backward with His shoulders against the wood. The legionnaire feels for the depression at the front of the wrist. He drives a heavy, square, wrought-iron nail (Figure 3) through the wrist and deep into the wood. Quickly, he moves to the other side and repeats the action, being careful not to pull the arms too tightly, but to allow some flexion and movement. The patibulum is then lifted in place at the top of the stipes and the titulus reading "Jesus of Nazareth, King of the Jews" is nailed in place.

The left foot is pressed backward against the right foot, and with both feet extended, toes down, a nail is driven through the arch of each, leaving the knees moderately flexed. The Victim is now crucified. As He slowly sags down with more weight on the nails in the wrists, excruciating, fiery pain shoots along the fingers and up the arms to explode in the brain—the nails in the wrists are putting pressure on the median nerves. As He pushes Himself upward to avoid this stretching torment, He places His full weight on the nail through His feet. Again there is the searing agony of the nail tearing through the nerves between the metatarsal bones of the feet.

At this point, another phenomenon occurs. As the arms fatigue, great waves of cramps sweep over the muscles, knotting them in deep, relentless, throbbing pain. With these cramps comes the inability to push Himself upward. Hanging by His arms, the pectoral muscles are paralyzed and the intercostal muscles are unable to act. Air can be drawn into the lungs, but cannot be exhaled. Jesus fights to raise Himself in order to get even one short breath. Finally, carbon dioxide builds up in the lungs and in the blood stream and the cramps partially subside. Spasmodically, He is able to push Himself upward to exhale and bring in the life-giving oxygen. It was undoubtedly during these periods that He uttered the seven short sentences which are recorded:



Figure 3

The first, looking down at the Roman soldiers throwing dice for His seamless garment, "Father forgive them for they know not what they do."

The second, to the penitent thief, "Today thou shalt be with me in Paradise."

The third, looking down at the terrified, grief stricken, adolescent John, (the beloved Apostle), he said, "Behold thy mother," and looking to Mary, his mother, "Woman, behold thy son."

The fourth cry is from the beginning of the 22nd Psalm, "My God, my God, why hast thou forsaken me?"

Hours of this limitless pain, cycles of twisting, joint-rending cramps, intermittent partial asphyxiation, searing pain as tissue is torn from His lacerated back as He moves up and down against the rough timber: Then another agony begins. A deep crushing pain deep in the chest as the pericardium slowly fills with serum and begins to compress the heart.

Let us remember again the 22nd Psalm (the 14th verse), "I am poured out like water, and all my bones are out of joint: my heart is like wax; it is melted in the midst of my bowels."

It is now almost over—the loss of tissue fluids has reached a critical level—the compressed heart is struggling to pump heavy, thick, sluggish blood into the tissues—the tortured lungs are making a frantic effort to gasp in small gulps of air. The markedly dehydrated tissues send their flood of stimuli to the brain.

Jesus gasps His fifth cry, "I thirst."

Let us remember another verse from the prophetic 22nd Psalm: "My strength is dried up like a potsherd; and my tongue cleaveth to my jaws; and thou hast brought me into the dust of death."

A sponge soaked in Posca, the cheap, sour wine which is the staple drink of the Roman legionnaires, is lifted to His lips. He apparently doesn't take any of the liquid. The body of Jesus is now in extremis, and He can feel the chill of death creeping through His tissues. This realization brings out His sixth words—possibly little more than a tortured whisper.

"It is finished."

His mission of atonement has been completed. Finally He can allow his body to die.

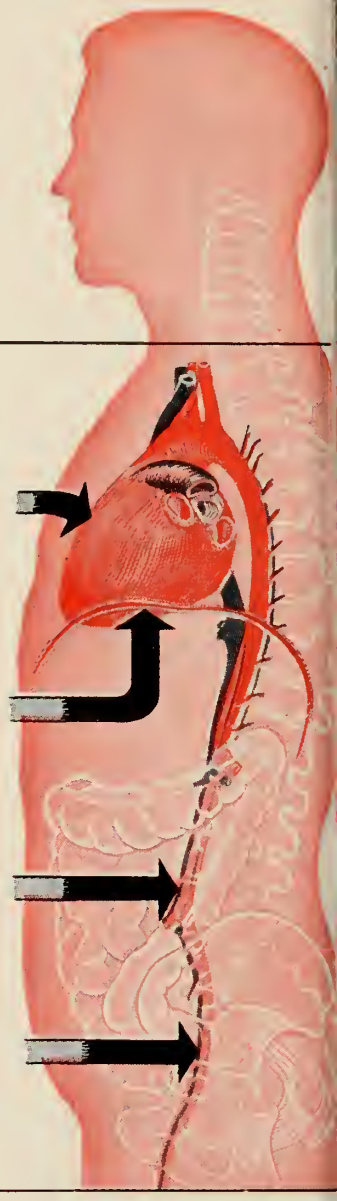
With one last surge of strength, He once again presses His torn feet against the nail, straightens His legs, takes a deeper breath, and utters His seventh and last cry, "Father, into thy hands I commit my spirit."

The rest you know. In order that the Sabbath not be profaned, the Jews asked that the condemned men be dispatched and removed from the crosses. The common method of ending a crucifixion was by crurifracture, the breaking of the bones of the legs. This prevented the victim from pushing himself upward; the tension could not be relieved from the muscles of the chest, and rapid suffocation occurred. The legs of the two thieves were broken, but when they came to Jesus they saw that this was unnecessary.

Apparently to make doubly sure of death, the legionnaire drove his lance through the fifth interspace between the ribs, upward through the pericardium and into the heart. The 34th verse of the 19th chapter of the Gospel according to St. John: "And immediately there came out blood and water." Thus there was an escape of watery fluid from the sac surrounding the heart and blood from the interior of the heart. We, therefore, have rather conclusive post-mortem evidence that Our Lord died, not the usual crucifixion death by suffocation, but of heart failure due to shock and constriction of the heart by fluid in the pericardium.

Thus we have seen a glimpse of the epitome of evil which man can exhibit toward man—and toward God. This is not a pretty sight and is apt to leave us despondent and depressed. How grateful we can be that we have a sequel: A glimpse of the infinite mercy of God toward man—the miracle of the atonement and the expectation of Easter morning!

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SEARLE

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Resuscitation Of The Newborn

By William A. Walker, M. D., F. A. A. P.

Decatur, Alabama

The ultimate product of any pregnancy should be a normal, healthy newborn. While the conduct of the pregnancy, labor and delivery are of great importance, the care of the infant immediately following birth also deserves much consideration. It is imperative that all who have the responsibility for the care of the newborn during the first minutes after birth be familiar with the indications for and the technic of resuscitation of the neonate.

The primary purpose of resuscitation of the newborn is to improve oxygen-carbon dioxide exchange by the facilitation of lung expansion. The asphyxic infant has a rapidly falling blood oxygen level and a rising carbon dioxide tension resulting in a lowered blood pH. Inasmuch as these changes take place in a very short period of time, it is important to evaluate and begin resuscitative measures promptly.

Evaluation Of The Newborn Infant

So that difficulty in resuscitation may be anticipated, the unborn infant must be followed closely in-utero. Bradycardia, with the fetal heart rate falling below 100 per minute, usually indicates asphyxia. Passage of meconium in a vertex delivery likewise is an indication of fetal distress. When these signs are present, a person skilled in resuscitative measures should be available at the time of delivery.

The majority of infants make the transition from intrauterine to extrauterine existence with no difficulty. One must have a systematic method for the evaluation of the newborn's condition. One such technic was devised by Apgar, utilizing the five following signs.

I. Heart rate—A pulse rate of below 100 per minute is a danger sign.

II. Respiratory effort—Most infants establish adequate breathing spontaneously in one minute. If not, immediate assistance is indicated.

III. Reflex irritability—Absence of a sneeze, grimace or cough when a catheter is placed in the nares indicates CNS depression.

IV. Muscle tone—A flaccid newborn is one in difficulty, frequently in shock.

V. Color—Newborns should assume a pink color in one to three minutes. Persistent cyanosis indicates need for resuscitative measures.

According to the method of Apgar these signs are evaluated at the end of one minute after birth. Each sign is given a score of zero, one, or two. A total score of ten indicates the best possible condition attainable by the infant. An infant with a score of five to ten usually needs no treatment. A score of four or below indicates need for immediate diagnosis and treatment. Ninety per cent of infants should score seven or above at age one minute.

General Care of Newborns

As soon as the umbilical cord is clamped

(Continued on Page 822)



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1. Weese, H.: Personal Communication, Sept. 25, 1964. 2. Glynn, R.: Obst. & Gynec. 20:369, 1962.

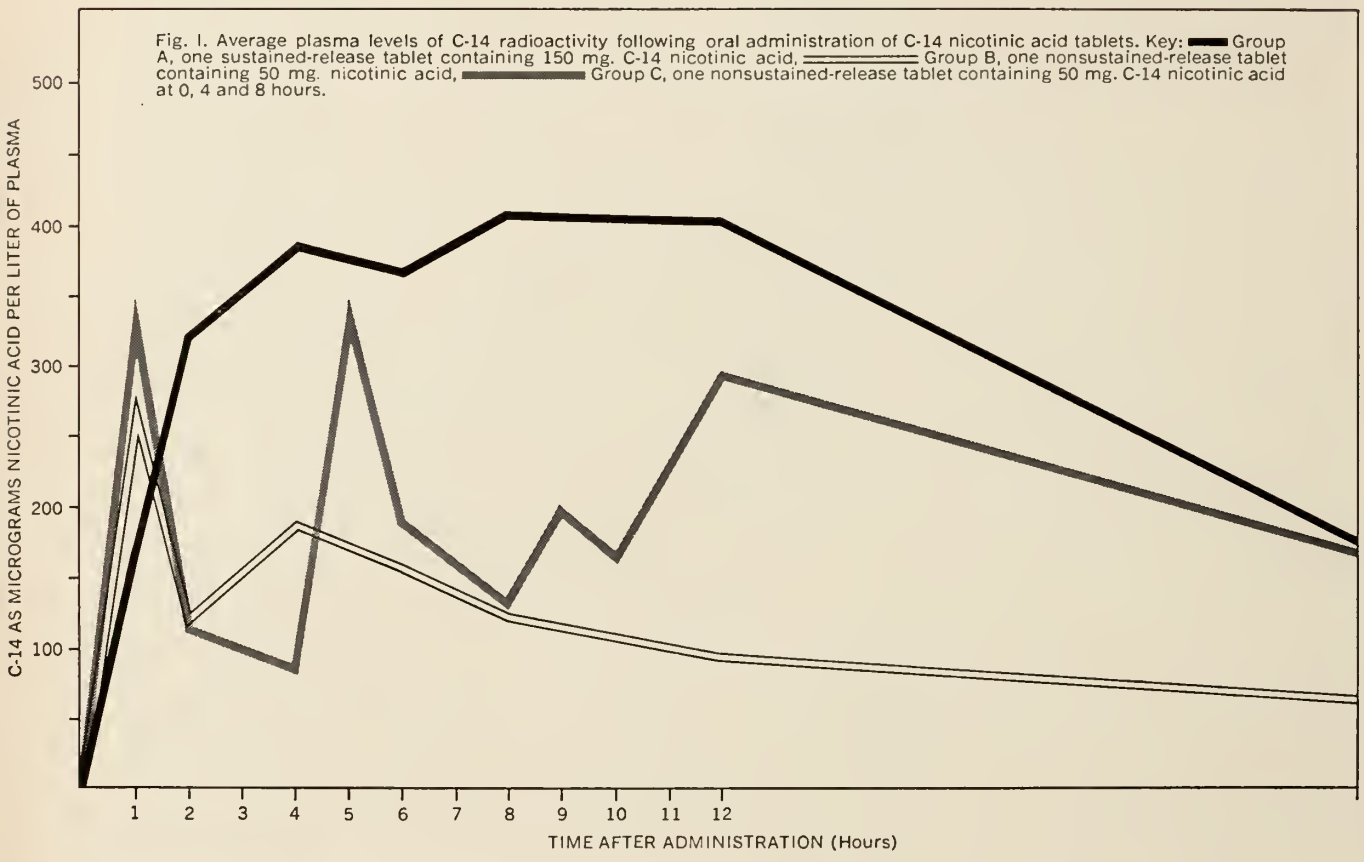
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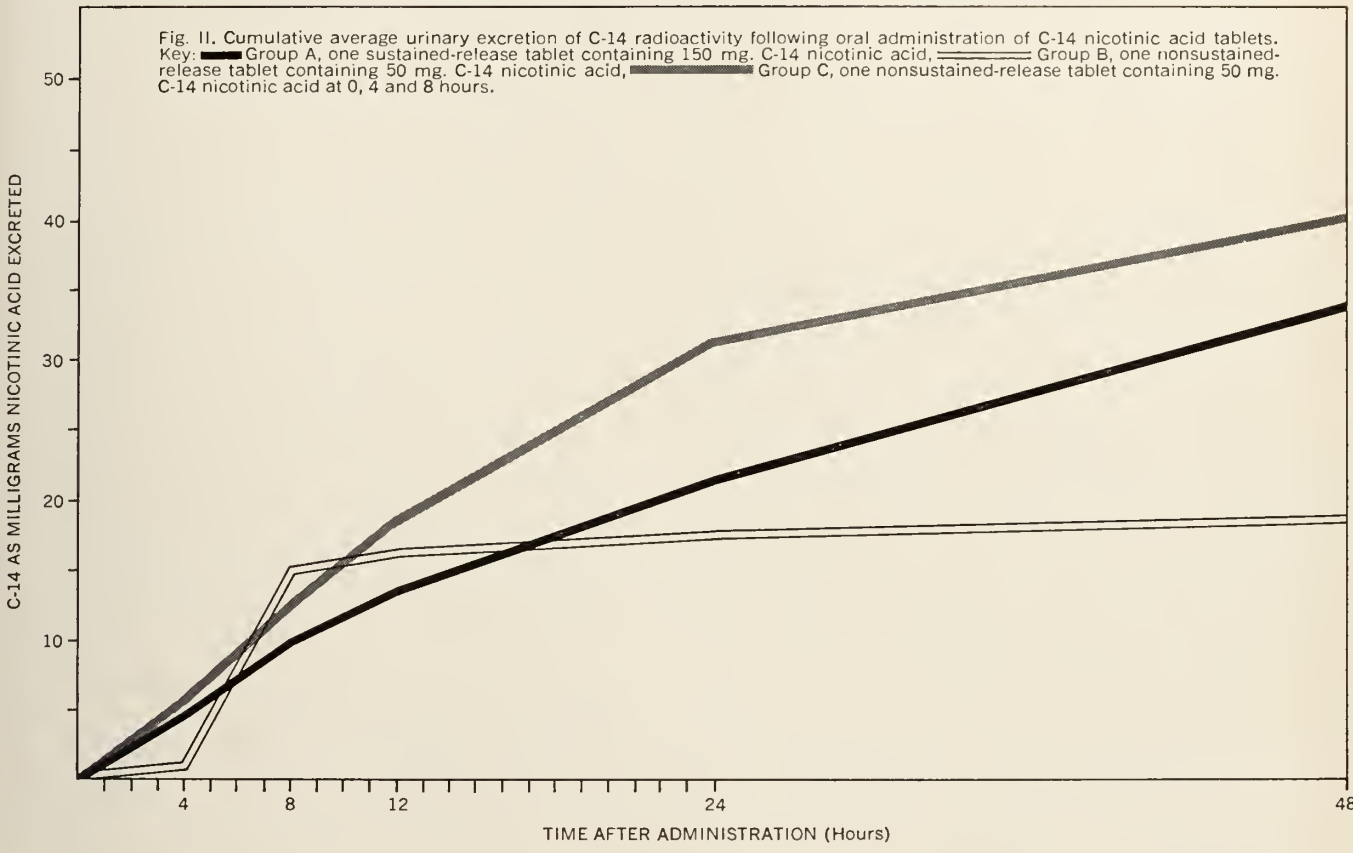
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Precautions: Exercise caution when treating patients with a low convulsive threshold.

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Dosage: One tablet every 12 hours.

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References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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RESUSCITATION OF THE NEWBORN

(Continued from Page 818)

all infants should receive gentle suction of the mouth, throat and nose. This may be accomplished with a soft rubber catheter and a DeLee glass trap or by using a bulb syringe. While the suctioning is being done the head should be in a dependent position to facilitate drainage of mucous and amniotic fluid. It is not necessary to hang the child by its heels, however, since venous pressure might rise to the point where risk of hemorrhage would be increased. There is no strong evidence that the maneuver is harmful but there is also no evidence that it is necessary. Jackknifing, compressing the chest, spanking, dilating the anal sphincter, tubbing or other manipulative procedures do no good and may do harm as well as delay proper therapy. While the clearing of the upper airway is being done the normal body temperature of the infant should be maintained. The rate of oxygen consumption is increased in the cold neonate.

If the infant breathes spontaneously and has an Apgar score of five to ten no other measures are usually needed.

Resuscitation Of The Infant In Poor Condition

The infants who have Apgar scores of four or below need special attention. Administration of oxygen is indicated after the airway has been cleared. In flaccid infants the tongue may obstruct the posterior pharynx. A small pharyngeal airway will correct this type obstruction. If the heart rate remains above 100 per minute and good reflex irritability is present in the apneic, flaccid child, gentle flicking of the heels often brings about crying and a deep breath.

If respirations continue to be absent or inadequate one may use the following technic. By placing a small rubber mask over the nose and mouth and using a bag resuscitator, positive pressure can be administered under controlled conditions. Positive pressures of 15 to 20 cm. of water are safe for repeated inflations when properly applied. It is occasionally necessary to use higher pressures, 40 to 50 cm. of water, for a very short period of time in order to expand the lungs initially. Auscultation of the chest should be done to ascertain that air is entering the lungs. The heart rate must also be monitored. In the flaccid, apneic infant whose pulse rate is below 100 per minute and falling, intubation of the trachea is indicated.

Intubation is a technic that should be mastered by all who care for newborn infants. The detailed description of laryngoscopy and intubation does not lend itself well to the printed word, therefore, only general remarks will be made here.

Direct visualization of the larynx using a laryngoscope with a premature blade is done. The mucous around the larynx is removed by gentle suction. A snugly fitting endotracheal tube is inserted. A small plastic suction tube facilitates clearing the trachea of mucous. Frequently this procedure produces a spontaneous gasp and breathing ensues.

If breathing does not begin, intermittent positive pressure may be administered using the bag or by mouth to tube method. Using either method, high oxygen levels may be maintained by attaching oxygen to the bag or by placing an oxygen tube into the mouth of the operator using the mouth to tube method. It is of importance to auscultate the chest, as noted above, to ascertain that air is entering the lungs. In using mouth to tube positive pressure, only the air in the operator's mouth should be expelled into the tube. Expelling air from the operator's lungs may produce excessive pressure and rupture the infant's alveoli.

A severely depressed infant may require artificial ventilation for a prolonged period before spontaneous respiration occurs. Once the child breathes spontaneously, the endotracheal tube should be removed.

Medication

In general, drugs are to be used only incidentally along with the above mentioned resuscitation measures. If maternal opiates have been administered in large amounts before delivery, antagonists levallorphan (Lorfan) or nalorphan (Nalline) should be administered in appropriate amounts. Caffeine may be of some value in infants depressed by maternal barbiturates. As a rule, analeptic drugs are of no value in the hypoxic newborn infant.

Cultures of the pharyngeal and intratracheal contents should be taken when infants require vigorous resuscitative measures. It is suggested by some that prophylactic antibiotics are indicated in these infants. The danger of infection is, of course, greatest when mouth to tube resuscitation is done.

Other Measures

Evidence has been presented that some infants, who have an adequate heart beat just prior to birth but none at birth, may respond to external cardiac massage. These infants should be intubated and positive pressure oxygen enriched air administered. The middle portion of the sternum is compressed, thus massaging the heart against the vertebral column. Massage at the rate of 100 to 120 per minute should be interrupted while the lungs are being inflated. The effectiveness of the massage effort may be determined by palpation of the femoral pulse during the procedure.

The use of hyperbaric oxygen, alkaline intravenous infusions and other measures are still in the experimental stage and, as such, do not fall within the scope of this paper.

References

Apgar, V.: Current Res. in Anesth. and Analg. 32: 260, 1953.

Avery, M.: The Lung And Its Disorders In The Newborn Infant. Philadelphia, W. B. Saunders Co., 1964.

Cross, K. W.: Resuscitation of the Asphyxiated Infant. Br. Med. Bull. 22: 73-78, 1966.

Resuscitation of the Newborn Infant. Evanston, Illinois, American Academy of Pediatrics, 1958.

Weintraub, D. H.: Resuscitation of the Newborn. Clinical Pediatrics 3: 660-662, 1964.

Slide Set On Arterial System Is Available To Physicians

A set of slides to assist physicians in conducting a complete examination of the arterial system has been prepared by the American Heart Association.

The slides and an accompanying script constitute a professional education unit which emphasizes the common physical findings in occlusive arterial disease and the practical diagnostic procedures which can be carried out in the physician's office. Entitled "Examination of the Arterial System," the set of 29 color slides, contained in a three-ring binder, may be obtained by physicians, medical schools or hospitals on a loan or purchase basis, through local Heart Associations.

Grants Renewed For Study Of Problems Of Aged

NEW YORK, N. Y.—The American Geriatrics Society has renewed three $1800 grants to encourage resident physicians to devote more time to the study of the medical problems of the aging.

The grants will supplement salaries paid to resident physicians while they continue their medical education, and are made possible by Lederle Laboratories, a Division of American Cyanamid Company.

Application for grants should be addressed to the Chairman, Fellowship Committee, American Geriatrics Society, 10 Columbus Circle, New York, N. Y. 10019. Deadline for applications is June 1, 1966. Announcement of the awardees will be made at the AGS annual meeting June 23-24 at Chicago.

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All business and scientific sessions will be held in Mobile's mammoth new Municipal Auditorium, located a short walk from the convention hotel, the Admiral Semmes.

Although the first business session is not scheduled until 9 a. m. Thursday, April 21, the conclave will begin unofficially 24 hours earlier when golfing physicians tee off in the annual golf tournament at the Mobile Country Club Wednesday morning with Walter L. Hogan, Jr., M. D., in charge.

The MASA Board of Trustees will meet at 9 a. m. Wednesday in the Wallace Pitts Room of the Admiral Semmes Hotel. Exhibitors will register at 3 p. m. that afternoon.

The Alabama Thoracic Society and the Alabama Tuberculosis Association will present a symposium at 4 p. m. Wednesday at the Municipal Auditorium with all physicians invited to attend.

The Alumni Association of the Medical College of Alabama will have a reception and dinner beginning at 8 p. m. at the Mobile Country Club when installation of new officers will be held.

The Alabama Academy of Ophthalmology and Otolaryngology will convene at 6 p. m.

(Continued on Page 828)



The Rev. Dr. Paul B. McCleave

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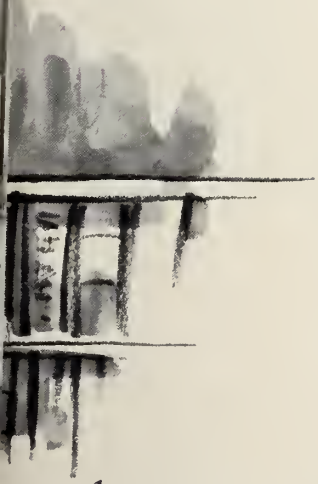
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(Continued from Page 824)

Wednesday at the Town House for a meeting devoted to the theme: "Our Changing World."

Officers of the Mobile County Medical Society are: George W. Newburn, Jr., M. D., President; Neal S. Flowers, M. D., President-Elect; Herbert V. Allen, M. D., Secretary; and, William P. Coats, M. D., Treasurer. The Program Committee is composed of James G. Donald, M. D., President of MASA and Chairman; William J. Atkinson, M. D., Chairman, Department of Medicine, Mobile General Hospital; Howard S. J. Walker, Jr., M. D., Chairman, Department of Surgery, Mobile General Hospital; and O. M. Otts, M. D., Chairman, Department of Ob-Gyn, Mobile General Hospital.

Scientific exhibits will be under the direction of Charles J. Hollis, M. D., of Mobile.

Dr. Donald will call the first business session to order with Reverend Dr. Paul B. McCleave, Director, Department of Medicine and Religion, AMA, giving the invocation. Welcome addresses will be made by Mayor Joseph Langan and George W. Newburn, Jr., M. D., President of the Mobile County Medical Society.

Immediately following will be the orientation program for new physicians with President-Elect J. O. Finney, Sr., M. D., presiding. Participants will include:

William L. Smith, M. D., Secretary-Treasurer of MASA, discussing county medical society organization and activities; Robert Parker, M. D., of Montgomery discussing the State Board of Censors; Ira L. Myers, M. D., State Health Officer, discussing State Board of Health and county affiliates; William J. Atkinson, M. D.. of Mobile discussing the committees of the Association; Tinsley R. Harrison, M. D., discussing ethics; Dr. M. Vaun Adams of Mobile discussing Medicare; Dr. E. B. Glenn of Birmingham discussing AMPAC-ALAPAC; William E. Lawrence, M. D., of Birmingham discussing Blue Cross-Blue Shield; Dean S. Richardson Hill, Jr., M. D., of Birmingham discussing the Medical College of Alabama; Mrs. James F. Crenshaw discussing the Woman's Auxiliary; and Dr. McCleave discussing medicine and religion.

The annual President's Message will be delivered by Dr. Donald to conclude the first business session.

The first scientific program begins at 2 p. m. Thursday with the following participants:

Orville W. Clayton, M. D., (Carcinoma of the Lung—Personal Experience with 1600 Patients); Gene V. Ball, M. D., of Birmingham (Modern Concepts in the Management



Dr. William Patton



Dr. James T. Priestley



Dr. Herschell P. Bentley, Jr.

of Gout); John C. Fridge, M. D., of Mobile (Anuria Due to Shock or Obstruction); T. Albert Farmer, Jr., M. D., of Birmingham (The Use of Estrogens in the Post-Menopausal Female with Special Reference to Coronary Disease); William Patton, M. D., of Mobile (Use of the Riechert-Mundinger Stereotactic Apparatus in the Treatment of Parkinson's Disease); James T. Priestley, M. D., of Rochester, Minnesota (Pancreatitis: Diagnosis and Treatment); Herschell P. Bentley, Jr., M. D., of Birmingham (Neo-Natal Mortality).

The second scientific session will begin at 9 a. m. Friday with Dr. Donald presiding. The program will include:

O. Thomas Bolding, M. D., of Birmingham (Intrauterine Devices); James D. Hardy, M. D., of Jackson, Mississippi (Problems Associated with Gastric Surgery); Wendell G. Scott, M. D., of St. Louis, Missouri (Preventable and Avoidable Cancers, and Cancers Arising from Personal Indifference).

At 10:30 a. m. the scientific sessions will be recessed to hear an address by Charles Hudson, M. D., President-Elect of AMA, on "The 1965 Social Security Amendments: A Major Challenge."

At 11 a. m. recognition will be extended to members who have practiced medicine for 50 years. Awards will be given as follows: William Crawford Gorgas Award to Dr. Emmett B. Carmichael, Assistant Dean of Medical College of Alabama and the University of Alabama School of Dentistry; the William Sanders Award for public health contribution to J. S. Tarwater, M. D., Director of the State Department of Mental Health and co-ordinator of state mental health facilities; and the Douglas L. Cannon reporting award to Miss Anita Smith, staff writer for *The Birmingham News,* and Winfred Turner, *Decatur Daily* state editor.

The highlight of the convention will come at 11:15 a. m. Thursday when Lester Dragstedt, M. D., Research Professor of Surgery, University of Florida, delivers the Jerome Cochran Lecture. His subject will be "The Pathogenesis and Surgical Treatment of Gastric Ulcer."

Following the lecture the Alabama Medical Political Action Committee (ALAPAC) will sponsor a luncheon at the Municipal Auditorium with U. S. Rep. Durwood Hall, M. D., of Springfield, Missouri, as speaker.

Other luncheons will be sponsored by the

(See next page)



Dr. O. Thomas Bolding



Dr. James D. Hardy



Dr. Wendell G. Scott

Woman's Auxiliary and by the Alabama Radiological Society. The Auxiliary luncheon will be held at the Sheraton Battle House Hotel; the radiologists will lunch at the Admiral Semmes.

Featured speaker at the Auxiliary luncheon will be Mrs. Richard A. Sutter, President of the national Woman's Auxiliary. Mrs. G. William Wills, President of the Mobile County Medical Auxiliary, will preside.

The scientific program will be resumed at 2 p. m. Friday with Dr. Atkinson presiding. Participants will be as follows: W. Frank Cope, Jr., M. D., of Mobile (Shock in CNS Injuries); E. Stanley Crawford, M. D., of Houston, Texas (Vascular Disorders); Gus G. Casten, M. D., of Birmingham (Shock in Coronary Occlusion); and Richard Lilleihei, M. D., of Minneapolis, Minn. (Bacteremic Shock).

At 4 p. m. a panel on "Shock" will be presented, moderated by Dr. James D. Hardy of Jackson, Mississippi. Panelists will be Dr. Lilleihei, Dr. Crawford, Dr. Casten, and Dr. Edwards.

The final business session will convene at 9 a. m. Saturday at the Municipal Auditorium with Dr. Donald presiding. Delegates will be sitting as the Board of Health of the State of Alabama.

Following a report by the Board of Censors and revision of the rolls, new officers will be elected and installed.

Dr. James O. Finney, Sr., of Gadsden will automatically succeed to the Presidency. The office of Vice-President for this northeastern

(Continued on Page 832)



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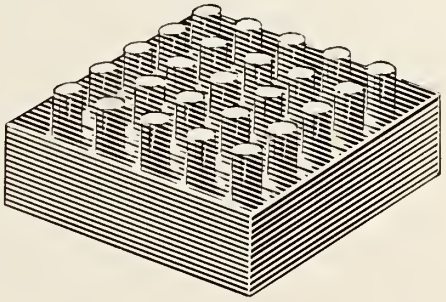


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*Rosenthal, S. R., Nikurs, L., Yordy, E., and Williams, W.: Scientific Exhibit Presented at the Annual Meeting of the National Tuberculosis Association, Chicago, Illinois, May 30-June 2, 1965.

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(Continued from Page 830)

division will be vacated by expiration of the term of Dr. H. E. Askin of Alexander City. Trustees whose terms expire this year are Dr. Bancroft Cooper of Elba, Dr. Buford Word of Birmingham, Dr. E. B. Glenn, Birmingham, as immediate Past President, Dr. W. L. Smith, Montgomery, as Secretary-Treasurer, and Dr. H. E. Askin, Alexander City, as Vice-President of the Northeastern District.

Fifty-year certificates will be awarded to the following physicians: Henry Beechum Burdeshaw of Dothan; Lewis Herschel Hamner of Camp Hill; William Perry Johnson of Hamilton; James Orville Morgan of Gadsden; Fred Dawson Reynolds of Montgomery; Cecil Hubert Ross of Mobile; William Llewellen Staggers of Benton; Lucius Lamar Terry of Sylacauga; Jesse James Walls of Alexander City; Jerre Watson of Anniston; and, Lewis Anthony Windham of Luverne.



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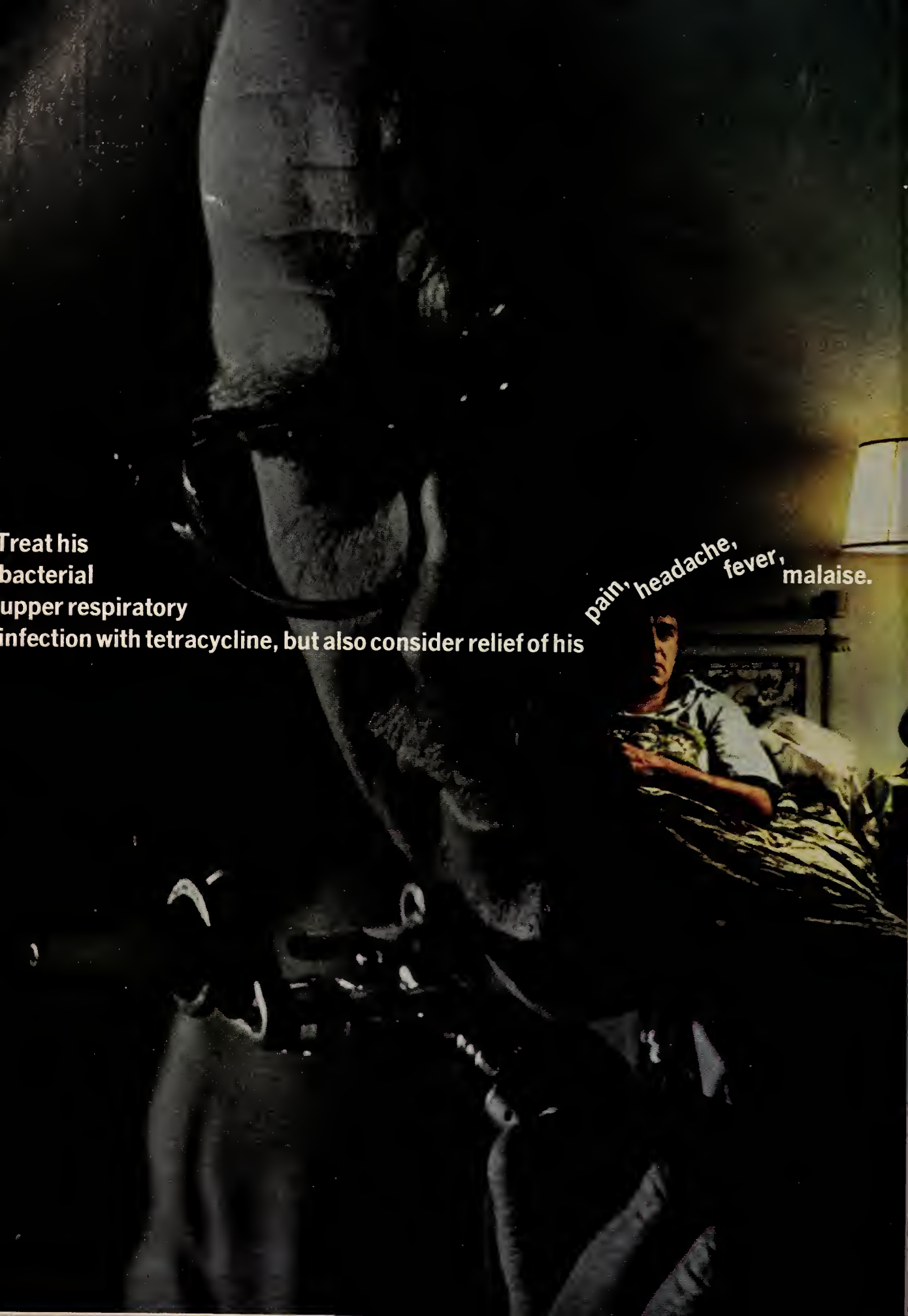
each cc. contains 6 mg. phenobarbital (warning: may be habit forming); 4 mg. Piptal® (pipenzolate bromide), and 20% alcohol.

Pleasant-tasting Pediatric Piptal with Phenobarbital is miscible in milk, formulas and fruit juices, and may also be given by dropper directly on the infant's tongue. Dosage is 0.5 cc. 15 minutes before feeding; in severe cases, 1.0 cc. four times daily. High doses may occasionally cause constipation with tenesmus and, rarely, flushing without fever. It is contraindicated in bowel obstruction or sensitivity to phenobarbital or anticholinergics. Available in 30 cc. dropper bottles, droppers calibrated to deliver 0.5 cc.

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References: 1. Roberts, C.E., Jr.; Perry, D.M.; Kuharic, H.A., and Kirby, W.M.M.: Arch. Int. Med. *107*:204 (Feb.) 1961. 2. Dowling, H.F.; Lepper, M.H., and Jackson, G.G.: Clin. Pharmacol. & Therap. *3*:564 (Sept.-Oct.) 1962. 3. Editorial: Antibiotics & Chemother. *11*:427 (July) 1961. 4. Baer, R.L., and Harber, L.C.: JAMA *192*:989 (June 14) 1965.

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MEDICAL CENTER NAMED MEDLARS SITE

The University of Alabama Medical Center has been designated as the third regional center for the MEDLARS (Medical Literature Analysis and Retrieval System) program of the National Library of Medicine, according to an announcement by Dr. Joseph Volker, Vice President for Health Affairs.

The Public Health Service is providing initial support in the amount of $82,804 for the Medical Center to serve as a reservoir for the vast informational sources in the health fields. Sources of scientific material will be stored on magnetic tapes and, through use of the Center's electronic computers, will be available to "all qualified persons" in the Southern region—Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee, Texas, Puerto Rico, and to organizations outside the region when referred by the National Library of Medicine.

All the information contained in **Index Medicus,** a monthly listing of references to health science publications, will be stored on magnetic tapes. The Medical Center's Research Coordinator, Dr. John Dunbar, is presently serving as director of the program.

Dr. Volker explained that the MEDLARS program in Washington is in the process of decentralizing its activities and is establishing several centers to serve various parts of the country. The first two designated centers are at the University of California Medical Center, Los Angeles, and the University of Colorado Medical Center, Denver.

Dr. Dunbar said that it will be some time, perhaps a year, before the program is in full operation. One of the prime difficulties, he said, would be in training people how to ask questions which the computers can answer. Computers can then be selective in choosing the correct types of literature relating to the subject.

Various personnel will be assigned duties for the program. Miss Dorothy Mueller, now with the Medical Center Library, will be chief "searcher." Miss Mueller is a reference library specialist. Center library personnel as well as computer specialists will be involved in the project, and all must have some knowledge in both fields. Searchers assigned to the program will receive training at the National Library of Medicine.

The Computer Laboratory at the Medical Center will adapt MEDLARS searching techniques so that Center computers can be utilized. J. Samuel Owen, manager of the Laboratory, will be in charge of the adaptation process.

Health professionals throughout the Southern area will be able to secure information sources, or bibliographies, on any given subject relating to health by contacting the Medical Center.

"There were several factors involved in our being selected," he said. "Our rapidly developing computer facilities; our strong library staff and the excellent diversity and number of medical publications included in our libraries, especially the distinctive Reynolds Historical Library; our central location —all contributed to the selection of this Medical Center as a MEDLARS regional center. This is also another indication of our recognition on a national level," Dr. Volker said.

The sheer volume of scientific information which has been, and continues to be published created a need for a more efficient retrieval system for bibliographies relating to the health sciences. Thus MEDLARS was created in 1960 as a service of the National Library of Medicine. Information sources were recorded on tapes which, when used in conjunction with computers, rendered the sources easily accessible. MEDLARS began to function in January 1964, and has operated as the principal retrieval center until the present time. Now MEDLARS is making the service available through regional centers.

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COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

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PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

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DR. VOLKER TO DELIVER DISTINGUISHED FACULTY LECTURE

The faculty of the University of Alabama Medical Center has chosen Dr. Joseph F. Volker, Vice President for Health Affairs, as recipient of the third annual Distinguished Faculty Lecturer Award.

Announcement of this selection at the Medical Center came from Dr. Frank Rose, President of the University of Alabama, speaking on behalf of the committee and its chairman, Dr. William J. Hammack.

The award is in recognition of the accomplishments of the Medical Center faculty members, evidenced by the advancement of the frontiers of health and science, and for outstanding contributions to the University of Alabama Medical Center through education, research and public service.

Dr. Volker will present a lecture to the faculty and friends of the Medical Center in the spring.

He came to the University of Alabama in 1948 to organize the School of Dentistry. Under his leadership as Dean, it became one of the world's outstanding centers of dental education. In 1955 Dr. Volker's academic activities were expanded to include other units of the Medical Center when he became Director of Research and Graduate Studies. The period of his service in this appointment was marked by substantial growth in the scope and number of Medical Center research and graduate programs. Dr. Volker's encouragement of young investigators and the creation of new and unique programs brought increasing recognition of the opportunities offered by the University in its Medical Center. In 1962 he became Vice President for Health Affairs with the administrative responsibility for all units of the Medical Center. His vision and broad interests contribute to its continued development.

Many significant contributions to the scientific literature, including sections of several widely used textbooks, have been made by Dr. Volker. His personal research interest has been in oral biochemistry, and he has published numerous observations pertinent to the control of dental caries, among them, the discovery that fluoride in solution could combine with the tooth surface and drastically modify its physical properties.

Previous recipients of the Distinguished Faculty Lecturer Award were Dr. Tinsley Harrison and the late Dr. Champ Lyons.

Aesculapius Award For Top Scientific Exhibit

The Medical Association of the State of Alabama, in cooperation with Mead Johnson Laboratories, will present the AESCULAPIUS AWARD to the author of the outstanding scientific exhibit shown at the 1966 Annual Meeting.

The exhibits will be judged by a committee of the Association. The winner will be presented with a certificate, suitably inscribed with the title of the exhibit and the author's name, and will receive a $200 prize donated by Mead Johnson Laboratories. Presentation will be made during the convention.

All exhibits accepted for showing at the 1966 Annual Meeting of the Medical Association of the State of Alabama will be eligible for judging. Physicians interested in submitting exhibits should make application to the Chairman, Scientific Exhibits Committee, The Medical Association of the State of Alabama, 2152 Airport Boulevard, Mobile, Alabama. (Dr. Charles J. Hollis)

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In Fractures: B and C vitamins are therapy

Stress formula vitamins are a key factor in bone and tissue regeneration. To meet the increased metabolic demands, STRESSCAPS offers therapeutic amounts of B and C vitamins as an aid to smoother convalescence and earlier rehabilitation. In fractures, as in many other conditions of physiologic stress, STRESSCAPS vitamins are therapy.

Each capsule contains:

Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
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Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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BRING IT DOWN AND KEEP IT DOWN



Metatensin lowers blood pressure and keeps it low—effectively and economically. It combines reserpine with trichlormethiazide which affords more potent saluresis with less loss of potassium than from earlier thiazides. Reserpine contributes antihypertensive effect by relieving anxiety and tension. Metatensin is well-tolerated over long periods; with its effectiveness and economy it assures antihypertensive therapy you and your patients can stay with.

METATENSIN®

Each scored tablet contains:
METAHYDRIN® (trichlormethiazide)
2 mg. or 4 mg. and
Reserpine 0.1 mg.

Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

Supplied: Metatensin tablets, 2 mg., 4 mg.—bottles of 100 and 1000.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE | PRODUCTS FOR PATIENTS YOU SEE EVERY DAY

ANSWERS TO QUESTIONS ABOUT MEDICARE PROGRAM

At the recent state-wide meeting sponsored by the Medical Association of Georgia, physicians propounded a number of written questions about some aspects of the new federal health insurance program.

The questions were edited and written replies made by the regional office of Health, Education, and Welfare. Copies were mailed to county medical societies in Georgia.

A similar service is available to physicians of Alabama. Any who have questions about the new law are invited to send them to:

Mr. Douglass M. Richard
Regional Representative
Bureau of Health Insurance
Department of Health, Education,
and Welfare
Peachtree-Seventh Building, Room 404
50 Seventh Street, N. E.
Atlanta, Georgia 30323

Following are some of the questions most frequently asked at the Georgia meeting:

What is meant by "Deductible" under the supplementary medical benefits plan (Part B) of Medicare?

The law provides that the total amount of expenses incurred under Part B by an individual during a calendar year shall be reduced by a deductible of $50. (The law permits the amount of the deductible for such calendar year to be reduced by the amount of any expenses incurred in the last three months of the preceding year and applied to the individual's deductible for that year.)

The $50 deductible under Part B for a calendar year does not have to be paid; it must only be incurred. Also, this deductible applies to total expenses incurred during the year, and not to each physician's fee.

Payments for physicians' services covered by Part B will be made on a reasonable charge basis. The $50 deductible will be subject to the same test of reasonableness as other expenses.

After the $50 annual deductible has been met, payment can be made for 80 per cent of the reasonable charges for the physician's (or other) services. Payment will be made by a carrier (1) to the patient on the basis of a receipted bill or (2) to the physician for an unpaid bill if the patient assigns payment to his physician and the physician agrees to the assignment and accepts the reasonable charge determination as the total amount of his bill.

Reimbursement by carriers for physician's and medical expenses under Part B will generally be made using the principle of applying the deductible and paying claims on the basis of incurred expenses as they are presented and proved to the carrier. This is in line with the practice already developed and currently followed in paying claims in the health insurance field.

What is the difference between an "intermediary" and a "carrier"?

Basically, an intermediary is a private or public organization or agency which serves as the Government's contracted agent to make payments for reasonable costs of inpatient hospital (and other provider) services and certain outpatient, laboratory and home health services. In short, the intermediary will reimburse for expenses covered by the hospital insurance part of the program (Part A).

A carrier is referred to in the law as a private insurance company, group health plan or voluntary medical insurance plan having experience in reimbursing physicians. Carriers will make payments for the reasonable charges of physician's services and other medical services under Part B.

Can a physician "participate" with some patients and choose to bill other patients as usual?

We assume "participate" means to accept assignment by the patient for direct payment from the carrier. If so, the answer is yes. It is entirely the physician's choice whether to

(Continued next page)

(Continued from Page 845)

accept assignment or to bill the patient in the regular way.

As stated above, if the physician accepts assignment for direct payment from a carrier for an unpaid bill, the physician must agree that the amount determined by the carrier as a reasonable charge for the service rendered will be considered the full amount of the bill.

If the physician bills the patient, the amount of the bill and the method of payment to the physician will concern only the physician and the patient. In cases such as this, the carrier will reimburse the patient for the reasonable charge of the service on the basis of a receipted bill.

Will the post-hospital home health care provisions under Part A pay the physician's fee?

No. Physicians' services are covered under Part B.

Who determines "reasonable charges"?

Where payment by the program is on the basis of charges (for physicians' services and medical and other health services not furnished by providers of services), the carriers are to take action to assure that the charge on which the reimbursement is based is reasonable and not higher than the charge used for reimbursement on behalf of the carriers' own policyholders or subscribers for comparable services and under comparable circumstances.

In determining reasonable charges, the carriers will have to consider the customary charges for similar services generally made by the physician or other person or organization furnishing the covered services, and also the prevailing charges in the locality for similar services.

The use by carriers of certain existing mechanisms and procedures will help in the determination of whether a charge is reasonable. For example, procedures established by State or local medical societies for resolving fee questions are regularly utilized by carriers.

Our hospital has not signed the Civil Rights Compliance Agreement. Is it true we are not eligible for Medicare? Will the physicians' bills be paid even though the hospital bill is not? How can we get the hospital authority to sign the Civil Rights Compliance?

Hospitals and other providers of services under Part A must be in full compliance with Title VI of the Civil Rights Act. However, payment for physicians' services under Part B is not affected by the Civil Rights Act.

Who decides on the acceptability of the utilization review plan?

The State agency will recommend to the Secretary those hospitals having a utilization review plan that meets the basic legal requirements of the law.

What steps are being taken for certification of private laboratories?

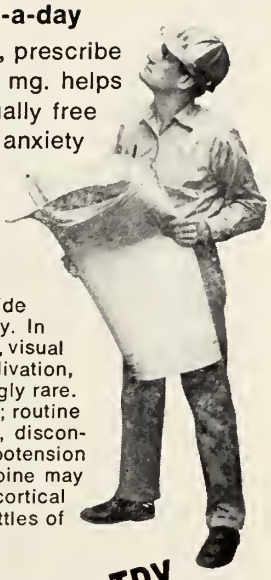
The Administration is completing work on the standards the State agency will apply in determining whether private laboratories meet the basic conditions for participation in the program. We expect completion of these standards soon.

World Congress Scheduled On Smoking And Health

NEW YORK, N. Y.--The First International Congress on Smoking & Health will be held at the New York Hilton Hotel in New York City June 5 to 7, 1966, announces Dr. Alton Ochsner, president of the Congress.

Blueprint for dealing with tension due to stress — Prolixin — once-a-day

For the patient who must be on the job mentally as well as physically, prescribe Prolixin. The prolonged tranquilizing action of as little as one or two mg. helps him cope with tension all day long. Markedly low in toxicity and virtually free from usual sedative effects, Prolixin is effective in controlling both anxiety associated with somatic disorders and anxiety due to environmental or emotional stress. Patient acceptance is good — because Prolixin is low in cost, low in dosage and low in sedative activity. Prescribe Prolixin.



Side Effects, Precautions, Contraindications: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photosensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders. **Available:** 1 mg. tablets. Bottles of 50 and 500. For full information, see Product Brief.

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PROLIXIN®

THE SQUIBB TRANQUILIZER

SQUIBB FLUPHENAZINE HYDROCHLORIDE

SQUIBB

Squibb Quality — the Priceless Ingredient



An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

Miltown® (meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

WALLACE LABORATORIES
Cranbury, N.J.

CM-5761



makes sleep irresistible

nidar®

EACH TABLET CONTAINS:

Pentobarbital Sodium	25 mg.
Secobarbital Sodium	25 mg.
Butabarbital Sodium	7.5 mg.
Phenobarbital	7.5 mg.

(WARNING: MAY BE HABIT FORMING)

ARMOUR PHARMACEUTICAL COMPANY
Chicago, Illinois, U.S.A.

nidar®

Sleep comes easy...lingers...departs naturally

Gentle doses of 4 barbiturates assure uninterrupted sleep

2 barbiturates act fast...in 20 to 30 minutes

2 long-range barbiturates come into play to sustain sleep for up to 8 hours

Tiny amounts of individual barbiturates means Nidar is well tolerated

Patients enjoy a refreshing, clear-headed wake-up

makes sleep irresistible



IN BRIEF:

EACH TABLET CONTAINS:

Pentobarbital Sodium	25 mg.
Secobarbital Sodium	25 mg.
Butabarbital Sodium	7.5 mg.
Phenobarbital	7.5 mg.

(WARNING: MAY BE HABIT FORMING)

Dosage: One or two tablets, one-half hour before bedtime.

Indications: For night-time sedation and refreshing sleep up to eight hours.

Contraindications: Patients sensitive to barbiturates. Use with caution in the presence of moderate to severe hepatic disease.

Supplied: Bottles of 100 tablets.

CAUTION: Federal law prohibits dispensing without a prescription.

ARMOUR PHARMACEUTICAL COMPANY
Chicago, Illinois, U.S.A.

OBITUARIES

REICH—Dr. Louis Adolph Reich died February 18 in Birmingham. He was 38 years of age. Dr. Reich was a graduate of Tulane University School of Medicine and had practiced in Alabama since 1959.

He was a member of the Jefferson County Poison Control Committee, secretary to the Jefferson County Chapter, AAGP, member of the Medical Association of the State of Alabama, American Academy of General Practice, and the American Medical Association.

Dr. Reich is survived by his wife and 4 children.

HOPE—Dr. John Crawford Hope, Sr., died at his home in Mobile at the age of 83. He retired from active practice ten years ago. He also was President of a tugboat company and operated two farms in Wilcox County.

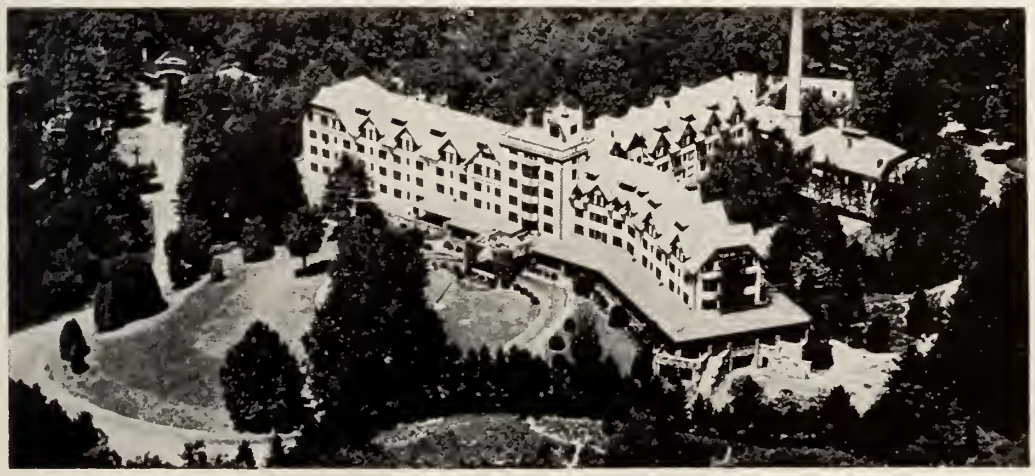
He was the first intern at the old Mobile City Hospital, now named Mobile General Hospital and served as city physician 32 years and county physician 29 years. He also was a member of the Mobile County Welfare Board 22 years.

Dr. Hope was a member of the Medical Society of Mobile County, Medical Association of the State of Alabama and the American Medical Association.

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ASHEVILLE NORTH CAROLINA



An institution for the diagnosis and treatment of psychiatric and neurological illnesses, rest, convalescence, drug and alcohol habituation.

Insulin coma, electroshock and psychotherapy are employed. The institution is equipped with complete laboratory facilities, including electroencephalography and x-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facilities for classification of patients, rooms single or en suite.

Wm. Ray Griffin, Jr., M. D.
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now...introducing a **new** high-strength dosage fo

SIGNEM

A 'MAXIMUM SECURITY' ANTIBIOTIC*

* THE BROAD RANGE DEPENDABILITY OF TETRACYCLINE
 long established as the broad-spectrum agent of first choice in a wide variety of infections
* WITH THE ADDED SECURITY OF MEDIUM-SPECTRUM REINFORCEMENT
 triacetyloleandomycin is highly active against the common 'coccal' pathogens, including certain strains of staphylococci resistant to penicillin and tetracycline
* ESPECIALLY VALUABLE IN U.R.I.
 provides decisive therapy in acute respiratory infections and other conditions in which staphylococci, streptococci or mixed flora are frequently encountered
* NOW AVAILABLE IN NEW STRENGTH FOR NEW CONVENIENCE AND ECONOMY
 Signemycin 375—high-potency capsules for simpler administration, greater patient economy

YCIN® 375

(tetracycline 250 mg. triacetyloleandomycin 125 mg.)

Indications: Indicated in the therapy of acute severe infections caused by susceptible organisms and primarily by bacteria more sensitive to the combination than to either component alone. In any infection in which the patient can be expected to respond to a single antibiotic, the combination is not recommended. Signemycin should not be used where a bacteriologically more effective or less toxic agent is available. *Triacetyloleandomycin, a constituent of Signemycin, has been associated with deleterious changes in liver function.* See precautions and adverse reactions.

Contraindications: Contraindicated in individuals who have shown hypersensitivity to any of its components. Not recommended for prophylaxis or in the management of infectious processes which may require more than 10 days of continuous therapy. If clinical judgement dictates therapy for longer periods, serial monitoring of liver function is recommended. Not recommended for subjects who have shown abnormal liver function tests, or hepatotoxic reactions to triacetyloleandomycin.

Precautions and Adverse Reactions: Triacetyloleandomycin, administered to adults in daily oral doses of 1.0 gm. for 10 or more days, may produce hepatic dysfunction and jaundice. Adults requiring 3 gm. of Signemycin initially should have liver function followed carefully and the dosage should be reduced as promptly as possible to the usual recommended range of 1.0 to 2.0 gm. per day. Present clinical experience indicates that the observed changes in liver function are reversible after discontinuation of the drug.

Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacetyloleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.

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Division, Chas. Pfizer & Co., Inc.
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New York, N.Y. 10017



The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—The Department of Health, Education and Welfare has issued strict guidelines prohibiting racial segregation in hospitals receiving money from the federal government.

The department said in a policy statement that schools, hospitals and nursing homes must adhere to the guidelines to continue receiving federal funds under the Civil Rights Act of 1964.

Surgeon General William H. Stewart of the Public Health Service said more than 10,000 hospitals receiving federal funds had been sent new rules and compliance reports. He said such hospitals must not separate or discriminate on the basis of race or national origin in the care and treatment of patients.

Hospitals are being asked "whether patients are assigned to all rooms and facilities without regard to race, color, or national origin; whether all persons are allowed to use entrances, admission offices, waiting rooms, dining areas and cafeterias, toilets and lavatories, and other service facilities; whether the hospital accepts and approves applications for staff privileges and training without regard to race, color, or national origin; and other similar questions," according to the HEW statement. "An up-to-date patient census by race must be indicated on the questionnaire, as must a breakdown by race of physicians holding staff privileges.

"If evidence of discriminatory practice is indicated in the returned questionnaire, the specific areas of failure to comply will be pointed out. The hospital will then be given an opportunity to eliminate its discriminatory practices as quickly as possible. Where discrimination persists, the hospital will be excluded from any new federal assistance programs, such as Health Insurance for the Aged (Medicare), which begins on July 1. When negotiations fail to achieve compliance, steps will be taken . . . to terminate present assistance, or compliance will be secured through enforcement by the courts.

The Office of Equal Health Opportunity is administratively located in the Office of the Surgeon General and will be headed by Mr. Robert M. Nash. It will employ a staff with special competencies and responsibilities in review and investigation of complaints, evaluation of complaint and compliance reports, public information activities, fiscal and statistical analysis, compliance negotiations, and development of recommendations for corrective action within the law, and will include experts in such areas as law, contracts, professional education and project grants, hospitals and nursing homes, and state and local health agencies.

An Office of Equal Health Opportunity has been set up by the PHS to monitor compliance with the Civil Rights law on behalf of all federal agencies in the health and medical fields.

"The Public Health Service intends to exert every effort to see that discrimination with respect to race, color or national origin is halted in all health and medical institutions and agencies receiving federal assistance," Stewart said.

* * *

The American Medical Association supports a legislative proposal for the federal licensing of dealers in research cats and dogs

(Continued on Page 856)



when the feeling of guilt overwhelms

NORPRAMIN®

(desipramine hydrochloride)

non-sedating • rapid-acting
ANTIDEPRESSANT

overcomes guilt, lifts depression, restores confidence

Feelings of guilt, worthlessness, emptiness and loss frequently characterize depression. Such feelings, along with insomnia, physical complaints, sadness, apprehension, and other symptoms of depression rapidly respond to Norpramin (desipramine hydrochloride). Improvement often begins in 2-5 days, sometimes in less. A few patients, sensitive to central nervous system stimulants may become restless as depression is lifted—in such cases dosage may be reduced or a tranquilizer added.

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions. **Dosage:** Optimal results are obtained at a dosage of two 25 mg. tablets t.i.d. (150 mg./day). **Contraindications and Precautions:** Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established. **Adverse Effects:** Side effects, usually mild may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs. **Supplied:** Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

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(Continued from Page 854)

to protect such pets from theft and insure their humane care.

The AMA opposes licensing of research laboratories themselves and sees no need to include other research animals in such a federal program.

In a statement submitted to House Agriculture Committee when it was considering such legislation, the AMA said:

". . . We firmly agree that any improper practices which do exist in the procurement of experimental animals should be corrected . . .

"The AMA supports the purposes of the provisions of the bill which afford protection to owners of cats and dogs from the practice of pet stealing," the AMA statement said. "The Association urges, however, that the provisions with respect to the licensing of research facilities (and the setting of standards), be deleted. We further urge that the bill be restricted to cats and dogs, and not include other vertebrate animals."

The AMA said there is no need for the government to supervise laboratories because "the standards of animal care in research facilities in the United States are generally high" and voluntary efforts "are effectively accomplishing the goal of maintaining good animal care in the laboratory."

As for protecting research mice, rats, guinea pigs, etc., from theft, the AMA pointed out that they rarely are pets and, with few exceptions, are obtained from a few national breeding laboratories which supply genetically pure inbred strains.

President Johnson is seeking Congressional approval of a $1 billion expansion of federal domestic health programs.

In a domestic health message to Congress, Johnson estimated that such programs, after the expansion, would cost the federal government $4.67 billion in the 1967 fiscal year beginning next July 1. In addition, medicare expenditures of social security tax funds are estimated at more than $3 billion for the year.

Johnson announced plans for:

—reorganization of health functions of the Department of Health, Education and Welfare.

—federal grants "to enable states and communities to plan the better use of manpower, facilities, and financial resources for comprehensive health services."

—programs to strengthen the nation's system of health care.

—a three-year program of federal aid in training of more health workers.

—an increase in medical research.

—additional steps to meet specific health problems such as alcoholism, birth control, mental retardation and nutrition.

Johnson also said that in fiscal 1968 he wants to start "new state formula grants for comprehensive health services" and additional grants to states, communities and hospitals to meet special health problems.

"To strengthen the nation's system of health care, the President proposed federal aid in modernization of obsolete hospitals, aid to group practice clinics, and research and demonstration projects in the organization, financing, utilization and delivery of health services."

But the program to provide government financing for group practice medical and dental centers ran into trouble in its first congressional test this year.

Wilbur J. Cohen, Assistant HEW Secretary, acknowledged under sharp questioning before a House Housing Subcommittee that no figures are available—since 1959—on how many group practice clinics have been financed through regular bank loans. Cohen testified that in 1946 there were 400 clinics for group practice and "nearly 2,000" now based on a projection of a 1959 figure study.

Johnson announced that HEW Secretary John W. Gardner had been directed to:

"—appoint an Advisory Committee on Alcoholism;

"—establish in the Public Health Service a center for research on the cause, prevention, control and treatment of alcoholism;

"—develop an education program in order to foster public understanding based on scientific fact;

"—work with public and private agencies on the state and local level to include this disease in comprehensive health programs."

The President said administration plans call for "a sizable increase" in expenditures for birth control research, training and services by the National Institute of Child Health and Human Development, HEW's Children Bureau and the Office of Economic Opportunity (poverty program).

May 15 Deadline For Heart Association Abstracts

May 15 is the deadline for submitting abstracts of papers to be presented at the American Heart Association's 1966 Scientific sessions October 21-23 in New York's Americana Hotel.

Papers should be based on original investigations in the cardiovascular or related fields. Abstracts should be limited to 250 words, briefly digesting results obtained and conclusions reached.

Official forms for submitting abstracts of papers and applications for scientific exhibit space may be obtained from Richard E. Hurley, M. D., American Heart Association, 44 East 23rd Street, New York, N. Y. 10010. Space for industrial exhibits may be requested through Steven K. Herlitz, Inc., 850 Third Avenue, New York, N. Y. 10022.

Sparkling Soft Drinks . . .

pleasure for patients who need liquids



Soft drinks are welcomed by patients on a liquid diet and by those who need additional fluids to maintain bodily functions. Since the amount of liquids is so important, flavorful soft drinks are often recommended. Carbonated beverages are useful for replenishing liquids when fever is present or when other foods and beverages cannot be tolerated. There's a psychological advantage, too—patient is happy to follow doctor's orders when they are so pleasant and enjoyable. Write for "Sparkling Soft Drinks" and "Liquids for Living."

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in common
anorectal disorders

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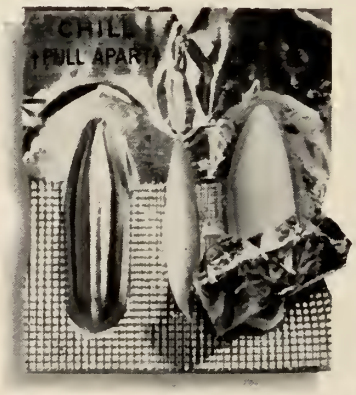
Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form...both are now available.

DIOTHANE OINTMENT

COMPOSITION:
diperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:
Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.





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DR. CHARLES WINKLER RECEIVES APPOINTMENT

Dr. Charles Winkler has accepted appointment as Assistant to the Vice President for Health Affairs with duties in the area of paramedical sciences effective the latter part of March, Dr. Joseph Volker, Vice President for Health Affairs, announced.

"Dr. Winkler has had a long and distinguished career as an academician within the University of Alabama. Although his primary appointment has been in the Department of Microbiology, he has participated in a number of cooperative research programs with medical and dental clinical scientists and has played a leading role in faculty affairs," Dr. Volker said.

Dr. Winkler first taught at the University of Arkansas School of Medicine in Little Rock. He then came to the University of Alabama Medical Center, where he has held appointments as assistant professor, associate professor and professor of microbiology, an appointment he will retain in his new assignment.

Surgeon General Names Three New Assistants

Surgeon General William H. Stewart of the Public Health Service has appointed three new Assistant Surgeons General.

Dr. Francis A. Arnold, Jr., Director of the National Institute of Dental Research, will be Chief Dental Officer of the Service. He succeeds Assistant Surgeon General Ralph S. Lloyd who retired.

Dr. David J. Sencer, Deputy Chief of the Communicable Disease Center, Atlanta, Ga., becomes Chief of the Center. He succeeds Assistant Surgeon General James L. Goddard, appointed Commissioner of the Food and Drug Administration.

Dr. Erwin S. Rabeau, Deputy Chief of the Division of Indian Health, is named Chief of that Division. He succeeds Assistant Surgeon General Carruth J. Wagner who became Chief of the Service's Bureau of Medical Services on December 23.

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Contact: Medical Director, Highland Hospital, Asheville, N.C. 28801

Alabama Department of Public Health

RADIUM SURVEY IN ALABAMA

William T. Willis, B. S., M. S., Director

Edward Cowan, B. S., M. P. H., Assistant Director

Division of Radiological Health

Bureau of Sanitation

A leak test and contamination survey of known sources of radium within the State has been completed by the Bureau of Sanitation of the Alabama Department of Public Health. Since a majority of the radium sources surveyed are used in medical practice, the results should be of interest to Alabama physicians.

Before discussing details of the survey, certain physical and chemical characteristics of radium should be described to assist in understanding why radium sources leak and why contamination occurs.

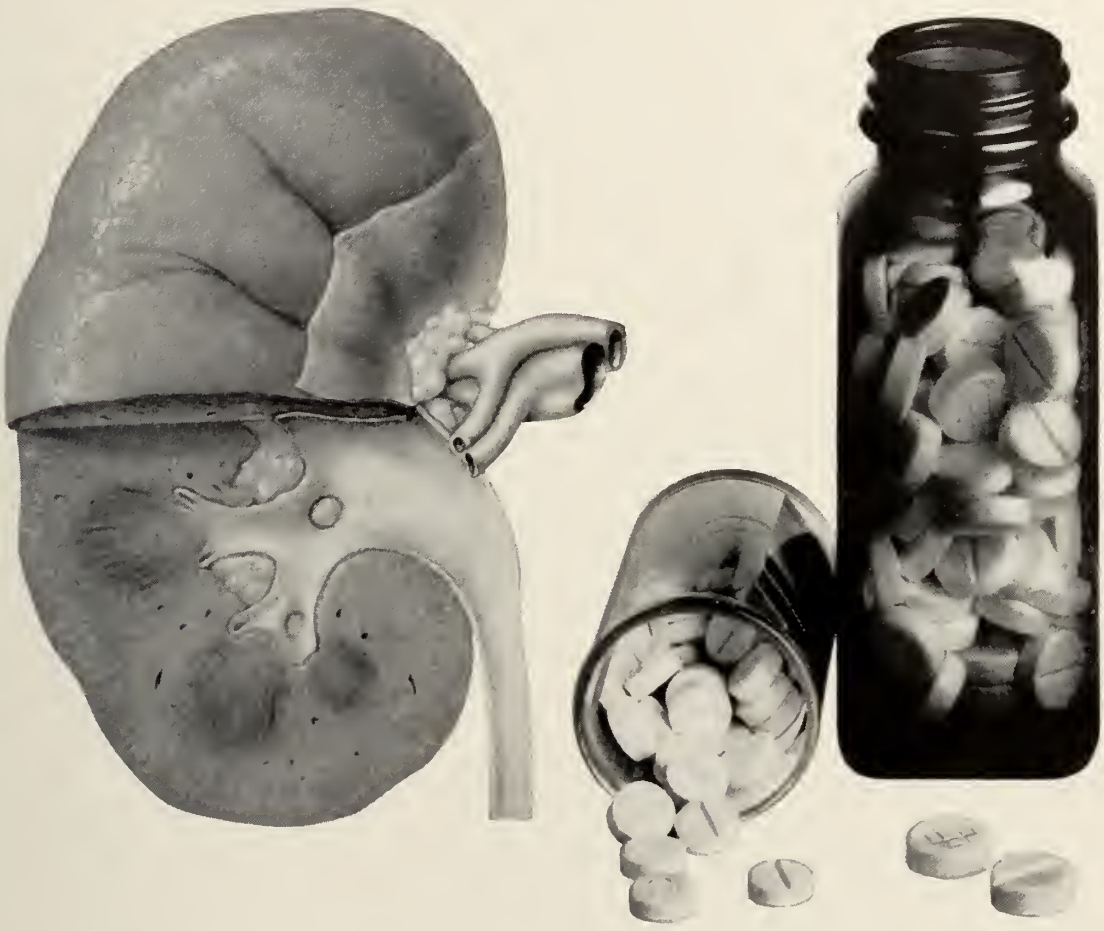
Radium used in medicine is in the form of a finely divided salt, usually radium sulfate. The radium salts are hermetically sealed in tubes, needles, cells or capsules. As the radium undergoes radioactive disintegration, or decays, radium changes into radon which is a gas. Radon, in turn, goes through a series of seven radioactive decay products ultimately becoming stable lead. Although only gamma radiation from radium sources is applicable in medical therapy, beta and alpha particles are also emitted. These particles are absorbed intentionally by 0.5 millimeters of gold or platinum. Ideally, the radium salts, the radon gas, and alpha and beta particles are completely contained within the radium source so that only the useful gamma rays penetrate the metal encapsulation. However, internal pressure which builds up inside the sealed source can affect the integrity of the hermetic seal of a radium source. This pressure is generated by the radon gas, the helium gas buildup from alpha decay, and from the generation of hydrogen and oxygen in the dissociation of moisture present as a result of inadequate drying of the salts before encapsulation. If the hermetic seal fails completely as a result of either internal pressure or external stress, a gross rupture occurs resulting in the release and spread of the radium powder.

Preventive measures to avoid a ruptured source are compelling when the consequences of a rupture incident are considered; such incidences represent a financial, as well as a public health, hazard.

Decontamination costs in several recorded incidents are unbelievably expensive. One industry spent $250,000 for decontamination following the rupture of a radium capsule. A source, however, need not be ruptured to allow the escape of radon and its daughter products. Small quantities of radon gas frequently leak from the source as a result of microscopic fissures. The leaking radon gas results in contamination but perhaps more importantly it serves as a warning sign that the source encapsulation has deteriorated portending possible trouble of a more serious nature, namely a gross rupture. Radium surveys are designed to detect leaking

(Continued on Page 862)

at Merck Sharp & Dohme...



understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

• Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

(Continued from Page 860)

sources before a serious rupture occurs and to decontaminate before serious problems develop.

Radium sources in Alabama have never been licensed, inspected, or subjected to State or Federal regulatory requirements. Other state health departments enforcing regulations relating to radium have found significant numbers of facilities with leaking radium sources and contaminated equipment.

During 1964 the Jefferson County Health Department surveyed all radium sources in Jefferson County to determine the kind and degree of radiation hazards. Conditions and practices were found to be inadequate. Four of the ten facilities surveyed had one or more leaking radium sources; three of the ten had significant quantities of contamination resulting from leaking sources. Physicians and representatives of industry viewed the survey as a service and showed their acceptance by responding favorably to the Jefferson County Health Department recommendations.

Encouraged by the accomplishments of the Jefferson County survey, the Alabama Department of Public Health conducted a similar survey for all radium users in the State. A survey plan was approved by the Alabama Radiation Advisory Board. This survey had three objectives:

1. To test all known sources of radium for leakage.
2. To determine the presence of contamination.
3. To train staff personnel in conducting inspections of radioactive materials.

Thirty-seven facilities were registered as having radium on their premises. The State Health Officer wrote each facility to explain the nature and purpose of the survey emphasizing that participation in the survey and compliance with Department recommendations would be entirely voluntary.

(Continued on Page 864)

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Formulas: Each 'Dexamyl' Spansule® Capsule (brand of sustained release capsule) No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming].

Principal cautions and side effects: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

Before prescribing, see SK&F product Prescribing Information.

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(Continued from Page 862)

Response to the letters exceeded expectations:

Letters to radium facilities	37
Response from facilities in one month	37
Wanted to participate	28
Did not want to participate	2
Did not possess radium	7

The two non-participating facilities asked to be included after a second letter further explained the intent of the survey.

Bureau of Sanitation personnel began the survey in April of 1965 with appointments being made with the users for all visits. For leak testing the sources, a procedure that is referred to as the "jar test method" was used. This test measures the alpha particles of radon daughters. A radium source is placed into a small glass jar and is sealed with a screw-on cap. After the source has remained in the closed jar for 24 hours, the jar lid is removed, turned over, and monitored with a gas flow proportional alpha instrument. An absence of alpha particles indicates that the source is not leaking and is not contaminated by a source that is leaking. Conversely, the detection of alpha particles means that the source is either leaking or has been contaminated with a leaking source.

The survey is concluded if the source is found not to be leaking. If the source is found to be leaking or contaminated, additional monitoring is performed for the storage container, equipment, and the premises to determine the extent of contamination. At the present time there are no uniform standards that differentiate between a leaking and non-leaking source. One-thousand alpha counts per minute was arbitrarily chosen to indicate a leaking source or contamination.

The following classification of facilities by type illustrates that the radium in Alabama is used primarily in the field of medicine and that it is used mostly by private physicians:

Type Facility	Number of Facilities
Hospitals	9
Private Physicians	18
Industrial	3
Total	30

The 30 facilities listed above possessed a total of 2638 milligrams of radium. The survey determined that 495 milligrams of this total were either leaking or contaminated. Thirteen of the 30 facilities possessed one or more leaking sources and all but one of the leakers were possessed by private physicians. These results can be seen more clearly in tabular form:

Type Facility	No. of Facilities	Facilities with Leakers
Hospitals	9	1
Private Physicians	18	12
Industrial	3	0
Total	30	13

A commercial firm had performed leak tests of radium sources at 7 facilities within the last two years. If routine leak testing is of value, one would expect to find fewer leakers among sources that had been leak tested previously. This was found to be true. The importance of periodic leak testing is shown by the data:

Facility Leak Testing Status	Number Facilities	Leaking Sources
Never Leak Tested Sources Before	23	12
Leak Tested Sources Within Last Two Years	7	1

Radium sources can be either owned or rented. Rented sources should be leak tested routinely by the renter; whereas, a high per cent of owned sources have never been leak tested. One would expect to find more leakers among owned sources than among rented

(Continued on Page 866)



the sedentary life is often the seat of low back pain

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strains

SOMA®
(CARISOPRODOL)

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(Continued from Page 864)

sources. The results document these expected results:

Type Possession	Number Facilities	Facilities with Leakers
Renters	11	2
Owners	20	11

By using 1000 alpha counts per minute as the minimum standard to indicate a leaking source, it was thought that some of the test results might group around the standard creating borderline situations. This did not prove to be the case. The following results point out that there were no marginal leakers and that the largest per cent of leakers were, in fact, heavily leaking:

Number Facilities	Leaking Activity Range (Counts Per Minute)
2	1,000 to 25,000
4	25,000 to 50,000
0	50,000 to 75,000
7	75,000 to 100,000 plus

Whenever a leaking radium source was found, contamination of the immediate area was also found. This was expected. Oddly enough, contamination was also present at five facilities which did not possess a leaking source. This finding supports the proposition that sources can leak intermittently. It is interesting to note that, generally, the contamination was confined quite closely to the area of the storage container and in no case was it wide-spread. This fact minimized the contamination hazard and made decontamination easy.

Following the survey, a letter was sent to each facility stating the survey findings and, when applicable, making recommendations concerning leaking sources and contaminated areas. Decontamination was accomplished at each facility where contamination was found. Decontamination procedures in these cases involved only a simple process of washing and scrubbing. In no case was contamination serious enough to justify the procurement of decontamination services from a commercial firm. Leaking sources at all but one facility were either disposed of or re-encapsulated. Through an arrangement with the U. S. Public Health Service, disposal was accomplished without cost to the facility. The amount of radium disposed is indicative of the weak radium market:

User	Milligrams of Radium Disposed
Private Physicians	212
Hospitals	45

Not all facilities chose to dispose of leaking sources. In preference to disposal, a total of 105 milligrams were re-encapsulated.

It might be helpful to summarize the salient survey findings and subsequent corrections. A total of 30 radium facilities was surveyed. Thirteen of the facilities had one or more leaking sources. Twelve facilities fully complied with recommendations for disposal or re-encapsulation. Recommendations were made for six facilities to decontaminate, and all six complied. Only one radium user has not complied with our recommendations, and this is the result of indecision over what action to take rather than a refusal to act.

The radium survey was a complete success. The reception given the survey team by physicians could not have been more satisfactory. Voluntary compliance by physicians with recommendations of the Bureau of Sanitation was excellent. The physicians' willingness to participate voluntarily in the survey and their eagerness to comply with recommendations indicates that they were pleased with the service.

REFERENCES

1. Gallaghar, R. G., and Saenger, E. L.: Radium Capsules and Their Associated Hazards. Amer J. Roentgen 77: 511-523, March 1957

2. Villforth, J. C.: Technical Problems in Controlling Radium. Paper presented at 91st annual meeting, American Public Health Association, Kansas City, Missouri, November 11-15, 1963

3. Gallaghar, Robert G., and McAllister, R. G.: Testing Radium Capsules for Radon Leakage. Health Physics Journal, Vol. 90, No. 2, August 1963

Mental anguish as a recoverable item of damages

The defendant physician, a general practitioner, was rendering prenatal care to the female plaintiff. Approximately two months before the estimated date of delivery and in the course of a routine examination, the defendant discovered that the fetus had died in utero. He did not disclose this fact to the patient or her husband. Furthermore, he did not discuss with the patient or her husband the advisability of waiting for the spontaneous evacuation of the dead fetus.

Thereafter, another physician, who had diagnosed an extrauterine pregnancy, performed a hysterotomy upon the female plaintiff. The female plaintiff sued the defendant for malpractice, alleging injuries and mental anguish, and her husband sued for loss of services.

On the trial there was expert testimony that the failure to tell the patient of the presence of the dead fetus comprised a departure from accepted medical practice. The jury returned a verdict of $9,000, in favor of the female plaintiff and of $1,000, in favor of her husband.

The defendant appealed. The Appellate Division reversed the judgment in favor of the husband and dismissed his complaint. The court further reversed the judgment in favor of the female plaintiff and granted a new trial unless she agreed to accept a verdict of only $2,500.

In reaching its conclusion the court stated: "[al]though [the] failure to disclose constituted a departure from accepted medical practice, we are nevertheless of the opinion that the evidence adduced failed to establish any proximate causal relationship between that departure and the hysterotomy performed by another physician whom the plaintiffs had consulted. The hysterotomy was concededly based upon an erroneous diagnosis of extrauterine pregnancy and was not performed because of the presence of the dead fetus. Hence, the damages flowing therefrom, including those claimed for loss of services, and medical expenses, could not be attributed to anything defendant did or failed to do." Here the court reiterated and reemphasized the principle that a mere departure from accepted standards is not compensable in a medical malpractice action. In order to recover, there must be a showing that the injuries claimed were "proximately caused" by the departure from accepted standards.

The court did find that the female plaintiff was entitled to some recovery. The court found that the failure of the defendant to disclose the presence of the dead fetus was the "proximate cause" of the female plaintiff's mental anguish. The plaintiff was entitled to recover for her mental anguish. However, the verdict of $9,000, reached in the presence of the testimony of the later hysterotomy and its attendant expenses was excessive and the recovery would be limited to $2,500.

Reprinted from New York State Journal of Medicine.

USPHS Will Purchase 1.5 Million Vaccines

The U. S. Public Health Service will buy at least one and one-half million doses of vaccine during the next year to protect preschool children against measles, Surgeon General William H. Stewart announces.

The vaccine will be offered to health departments receiving project grants under the national Vaccination Assistance Act. The Public Health Service will pay 68 cents a dose for the vaccine, including gamma globulin to be used in conjunction with the vaccine to minimize reactions.

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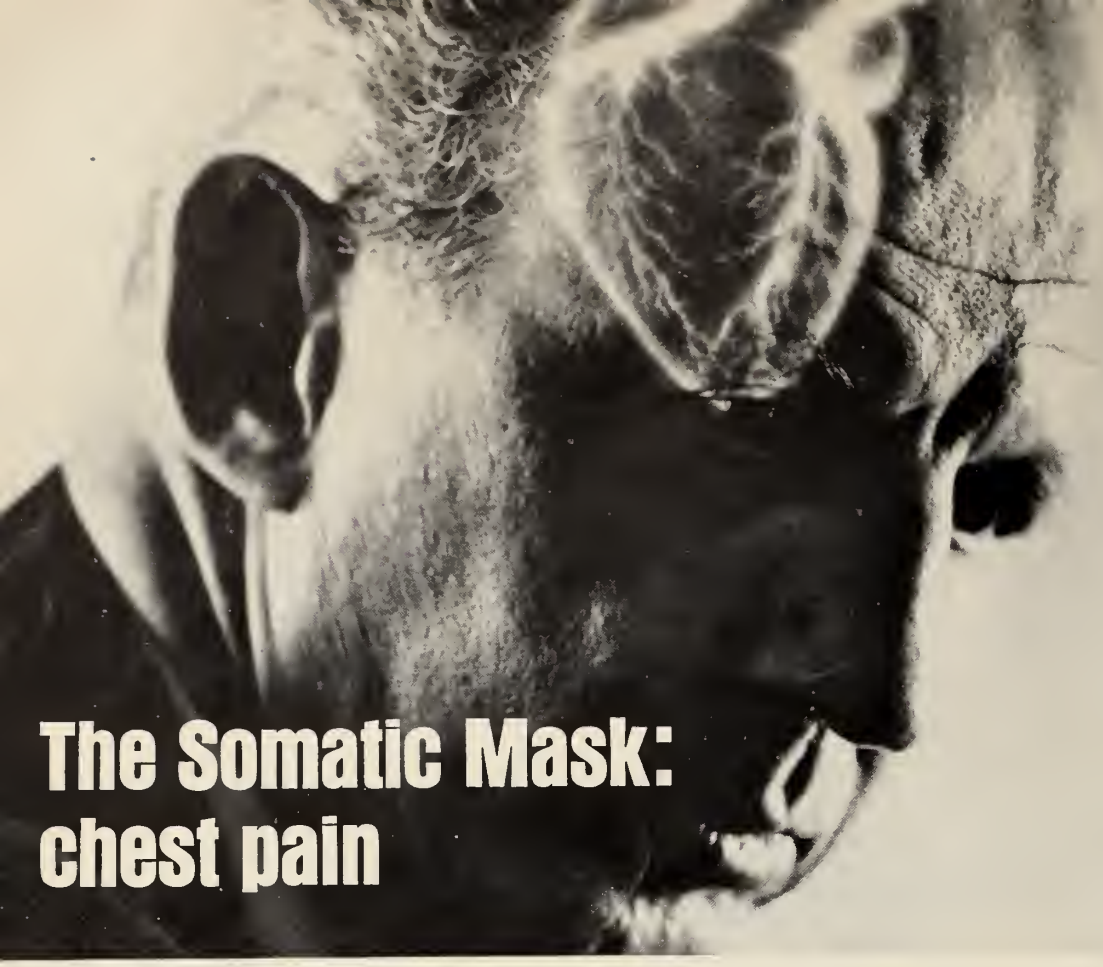
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Neurotic fatigue—the chronic tiredness resulting from emotional strain which so often accompanies psychogenic "heart" symptoms—also can be controlled by this highly useful agent. Valium (diazepam) often achieves results where other psychotherapeutic agents have failed.

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Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal or hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

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MAY 1966

INDICATIONS: Grand mal epilepsy and certain other convulsive states.

PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced.

SIDE EFFECTS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Upon discontinuation of therapy eruptions usually subside. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Though mild and rarely an indication for stopping dosage, gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered, especially in children, adolescents, and young adults. During initial treatment, minor side effects may include gastric distress, nausea, weight loss, transient nervousness, sleeplessness, and a feeling of unsteadiness. All usually subside with continued use. Hematologic disorders, including megaloblastic anemia, leukopenia, granulocytopenia, pancytopenia, and aplastic anemia have been reported. Nystagmus may develop.

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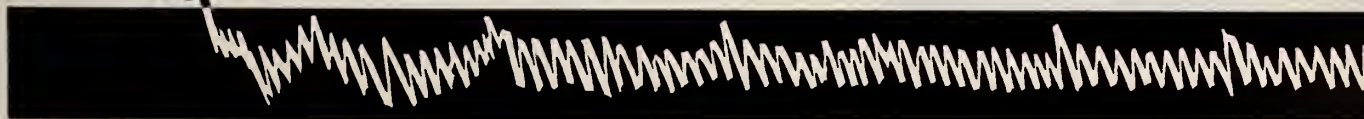
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President's Page



Dr. J. O. Finney

The entire membership of the Medical Association of the State of Alabama is deeply indebted to Dr. James G. Donald, who led us in such a magnificent way through the trials and tribulations of the past year. His tenure as President was marked by selfless devotion to time-consuming responsibilities, extraordinarily effective diplomacy in the handling of both intramural and extramural affairs of the Association, a careful personal study of our problems in every area of his jurisdiction, and patient persistence against adversities threatening our goals. To him we must say, "Thank You and Well Done," but not goodbye.

Accomplishments of the Association last year were numerous. Legislative successes included increased appropriations for the Health Department, a bond issue for the Medical Center, a more realistic salary scale for professional employees, and a new medical scholarship law. The proceedings of the Board of Trustees were characterized by a steadily increasing awareness of its important role in the execution of the affairs of the Association. The members of the various committees worked hard and productively in the discharge of their respective responsibilities. The members of the central office again demonstrated superior loyalty and zeal in the day-to-day operation of our now relatively complex organization.

On past accomplishments we should dwell only long enough to express appreciation to those responsible for the goals thus far achieved. Ahead of us many problems must be confronted in various areas which will tax the acumen and industry of our Association for years to come. Legislative matters at both the state and national levels must be wrestled with by the day, the week and the month; the implementation of Medicare will present problems and, initially at least, much frustration to almost every practitioner in the state; establishment of a regional center for heart-cancer-stroke research within our state; the need of employing an attorney on a full-time basis, as recommended by three or four committees, must be determined, as must the question of an increase in dues, also recommended by certain committees; the Board of Censors, the Board of Trustees, and every committee consulted, including an Ad Hoc committee, has called for the administrative separation of Blue Cross-Blue Shield. These challenges by no means complete the list, but should emphasize the necessity for each of you to participate in at least ONE of our problems at SOME level.

I accept the duties and responsibilities of this office to which you have elected me with deep appreciation. There is also a pragmatic realization that the aims and purposes of the Association cannot be attained without the full co-operation of each member. I ask of you an eagerness to join with me in a year of hard work for the Medical Association of the State of Alabama.

J. O. Finney, M. D.

President



Editorial COMMENT

A NEW FISCAL YEAR—A NEW OPPORTUNITY

The curtain rises this month on a new fiscal year for the Medical Association of the State of Alabama. It is axiomatic to observe that the forthcoming twelve months will bring with them problems not even dreamed of at this hour.

Some of these problems will be scientific in nature and will require the best professional abilities extant to solve them or even to keep them in rein. The others will be secular in nature and will demand the deepest concentration and native intelligence our leaders can muster.

Dark though the days ahead may be, let us be realists enough to concede that all will not be pitch and gloom. There will be good days ahead, too. Some of our endeavors are surely to succeed beyond our fondest expectations. Many times will we come to the crossroads and be faced with decisions whether to turn to the left or to the right. Sometimes we will be wrong; sometimes we will be right.

It is inspiriting to know that the men who have been selected to steer this vessel through the shoals ahead are men of great intelligence and high integrity. Upon their shoulders have fallen the mantles of leadership—mantles worn by scores of outstanding men before them.

The Association is in good hands. It will be guided by men of peerless character, strong minds and great hearts.

These leaders can be depended upon to surround themselves with associates of equal character and ability. To all of the officers and the chairmen and committeemen of this Association will fall the gargantuan task of implementing the works begun by their predecessors and of carefully charting new and safe routes into unexplored regions.

An unpredictable number of hours will be devoted in the days ahead to mulling over matters of peculiar concern to this organization. Thousands of miles will be traveled to and from meetings that appear to continue incessantly.

To those who now are relinquishing the reins of leadership after faithful and honorable service the members of this Association owe a great debt of gratitude. In the trying months to come, it is inconceivable that they will not be called upon time and time again for advice and counsel which they, weighted by wisdom gained through experience, can render best.

The incoming President of MASA will bring into office with him a veritable corps of new committeemen whose mettle is yet to be tested. Let us hope that they will follow in

(Continued on Page 876)



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LIFE & CASUALTY

A NEW FISCAL YEAR

(Continued from Page 874)

the footsteps of their predecessors in performing their tasks faithfully and well.

The strength of MASA stems primarily from the continuity of service of its officers and committeemen. The President-Elect has a full year to prepare himself for the responsibilities of President. The immediate Past President has important duties as an ex officio member of the Board of Trustees plus key committee assignments awaiting him upon retirement as chief executive.

This system of continuity assures the Association that the experience of its leaders will be put to maximum advantage. The results of more than a century's existence prove the merit of the system.

ANOTHER FORM OF SOCIALIZATION

There is now pending in the Federal Congress a bill (H. R. 8282) which, if enacted, will socialize the work force of this nation to the same extent that the practice of medicine was socialized by passage of P. L. 89-97 (Medicare).

The fight against federalization of the State unemployment compensation systems is now mainly being waged by business and industry, which see such a law as a boon to the lazy and shiftless. When Big Brother in Washington has added this sizable bloc to the thousands of undeserving beneficiaries of womb-to-tomb medical-hospital-n u r s i n g home-drugs-dental and a myriad of other government-sponsored programs, there will no longer be a need for Federal elections.

The powers-that-be on the banks of the Potomac will possess a veritable meat cleaver to hold over the heads of recalcitrant voters who, directly or indirectly, benefit from the unemployment compensation p r o g r a m s. Whereas present recipients now are beholden to the State governments, it requires no great intelligence to determine whose water they will tote when Washington becomes the determining factor.

Business and industry know full well that the dispensation of weekly emoluments to the chronically unemployed can come only from their own profits and that the Congress can raise or lower taxes--and unemployment benefits—with the flicker of an eyelash.

When Medicare was the Great Issue of the day, industry stood staunchly by the side of Medicine in opposing its sweeping encompassment of the non-indigent. The leaders of industry recognized Medicare for what it truly was—a foot in the door by Liberal Government to give them a hammer lock on the lives of a large segment of the electorate.

Now another Great Issue is being stirred in the cauldron of Liberal Government—another hammer lock on another segment of our population. Heavy pressure can, and most assuredly will, be exerted on these millions of unemployed men and women when election days roll around.

The Bureaucrat in Washington will write the regulations for the Federal Unemployment Compensation law just as he is now writing them for Medicare. The finished product will, if history repeats itself, bear no resemblance to oratorical protestations and Fedicrat assurances now being heard.

The unemployed, like the ailing, are subject to all types of pressures. It takes only a little tightening of the purse strings to make them jump higher, and higher, and higher through the politician's hoop.

If you, as a physician, are as concerned about the further socialization of our daily lives as the facts warrant, then lose no time in writing to your Congressmen and Senators and stating your opinions.



New, Long-term Psychiatric Facility

The new forty bed Parkwood Hospital specializes in long-term treatment of the mentally ill. Under the direction of a Medical Director, the hospital facilities are available to over thirty psychiatrists who are on its staff. Parkwood provides a full complement of exceptional facilities including X-ray, laboratory, pharmacy, occupational and music therapy, patient beauty parlor and an outdoor recreational area. ☐ Special efforts were made to combine maximum patient comfort with a warm, secure, residential atmosphere readily conducive to psychotherapy. ☐ We will be pleased to provide further information upon request.

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MEDICAL CARE AND THE WELFARE STATE

By James Y. Griggs, Editor

St. Louis Medicine

Public Law 89-97, more commonly referred to as Medicare, is now a law of the land. It is a portion of the doctrine of the Welfare State which many of us have come to accept as a bright and shiny new invention which has the inherent capacity to solve the problems of mankind. It is well to pause and reflect, however, that as with any law which follows this theory that there are inherent dangers. We can learn some of these dangers by a brief glimpse into the history of Welfare States of the past taken from the works of Dr. Melchior Palyi, an American citizen of Hungarian descent, a distinguished, internationally recognized educator, author, and financial expert who has taught at the Universities of Chicago, Wisconsin, and Northwestern and was formerly Chief Economist to the Deutsch Bank in Berlin.

"The essential idea of the Welfare State is as old as known history. Its concept and mechanism—the systematic dispensing, through political channels, and without regard to productivity, of domestic wealth—were at the very core of the Greco-Latin states, of the medieval city, and of the post-Renaissance absolute monarchy. In the city republics, ancient and medieval, it meant bloody civil wars. Their constantly recurring violent quarrels about constitutional issues disguised better class-welfares to seize the power that was dispensing all benefits. Most of them went on the rocks of their internal struggles for economic privileges. A Lorenzo Magnifico in Florence or the Oligarchy of the Ten in Venice managed to "save" their cities by grabbing the power and robbing the citizens of their political freedom and civic rights.

"France's Henry IV in the 16th Century promised 'a chicken in every pot.' Her brilliant Colbert in the 17th Century and Prussia's enlightened Frederick the Great in the 18th Century, these forerunners of modern dictators, gloried in calling themselves the first servants of the nation. Their Police State used the Welfare State as its instrument, facade and justification as do modern dictatorships. In democracies the Welfare State is the beginning and the Police State the end.

"The 'mercantilist' princes of the 16th to 18th centuries developed the basic tenets of the modern Welfare State in a piecemeal fashion. Originally their prime concern was the balance of trade—the want of gold and silver. To that, domestic policy was subordinated except when political motives were uppermost, such as the fear of hunger riots which occurred time and again in England under the Tudors and Stuarts, forcing them to dispense humanitarianism.

"Bismark's fundamentally significant role in modern history is rarely understood. His middle of the road socialism was the connecting link between the old autocrats and the coming totalitarians. He thought he could overcome Marxism by his own brand of state socialism—just as Fabian socialists and Keynesians profess that their middle of the road statism keeps the totalitarian wolf from the door. The Bismarkian Social Insurance gave the welfarist Weimar government a dangerous foothold in the nation's capital market and taught it to grab for other footholds. In addition, the German compulsory medicine was more expensive than private health insurance and gave less in exchange. On top of that it was badly infected with corruption.

"Perhaps the most spectacular 'social' aspect of Nazism was its emphasis on health. That was not accidental. The health, or rather sickness, propaganda employed by Bismark elevated that aspect of social welfare to a prime political issue. Why were

(Continued on Page 883)

spring 1966

DORSEY Season

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Duodenal mucosa with ulcer crater—
Approx. 80× Magnification.



Loosening epithelial cells of nasal mucosa during early stage of cold—Approx. 1800× Magnification.

this issue: partners in misery

Partners in misery: common cold and duodenal ulcer*



A century or two ago our forefathers believed that the common cold was caused by an excess of evil humors. Today we regard these baleful humors as a result of the cold rather than its cause. Only in the last ten years have some of the offending viruses been cultivated, and we now know many others can be transmitted to human volunteers although they cannot yet be grown in the laboratory. Various body defenses react to infection by a virus, and in the respiratory tract the lung is protected by the phagocytic properties of the pulmonary alveolar macrophage.[1]

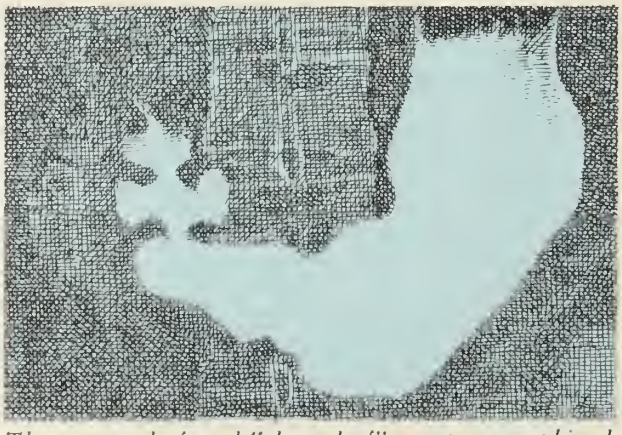
Because of the brief history and large proportion of unidentified viruses, effective prophylactic vaccines have not yet appeared. A universal antiviral agent seems even more remote. Meanwhile, these viruses continue to produce epidemics of upper respiratory infection at seasonal intervals, particularly in spring, fall and winter, during which they propagate and distribute progeny indiscriminately. As a result, they are responsible for significant work loss. Since the immunity afforded is temporary, recurrent infections are common.

This recurrent morbidity in spring and fall is shared by duodenal ulcer, itself a cause of significant loss in wages and medical expense. Thirty years ago Emery and Monroe reported 1,279 recurrences of peptic ulcer of which 13 per cent could be attributed to upper respiratory infection, thus confirming a long-held clinical impression.[2] While the inflammation, congestion and secretion of the mucosa of the nasopharynx in the common cold, and the hyperemia and hypersecretion of the gastric mucosa during acute exacerbation of a duodenal ulcer may not be directly linked, it is probable that the miseries of the infection are reflected in the pain of the ulcer. The following case history illustrates this point.

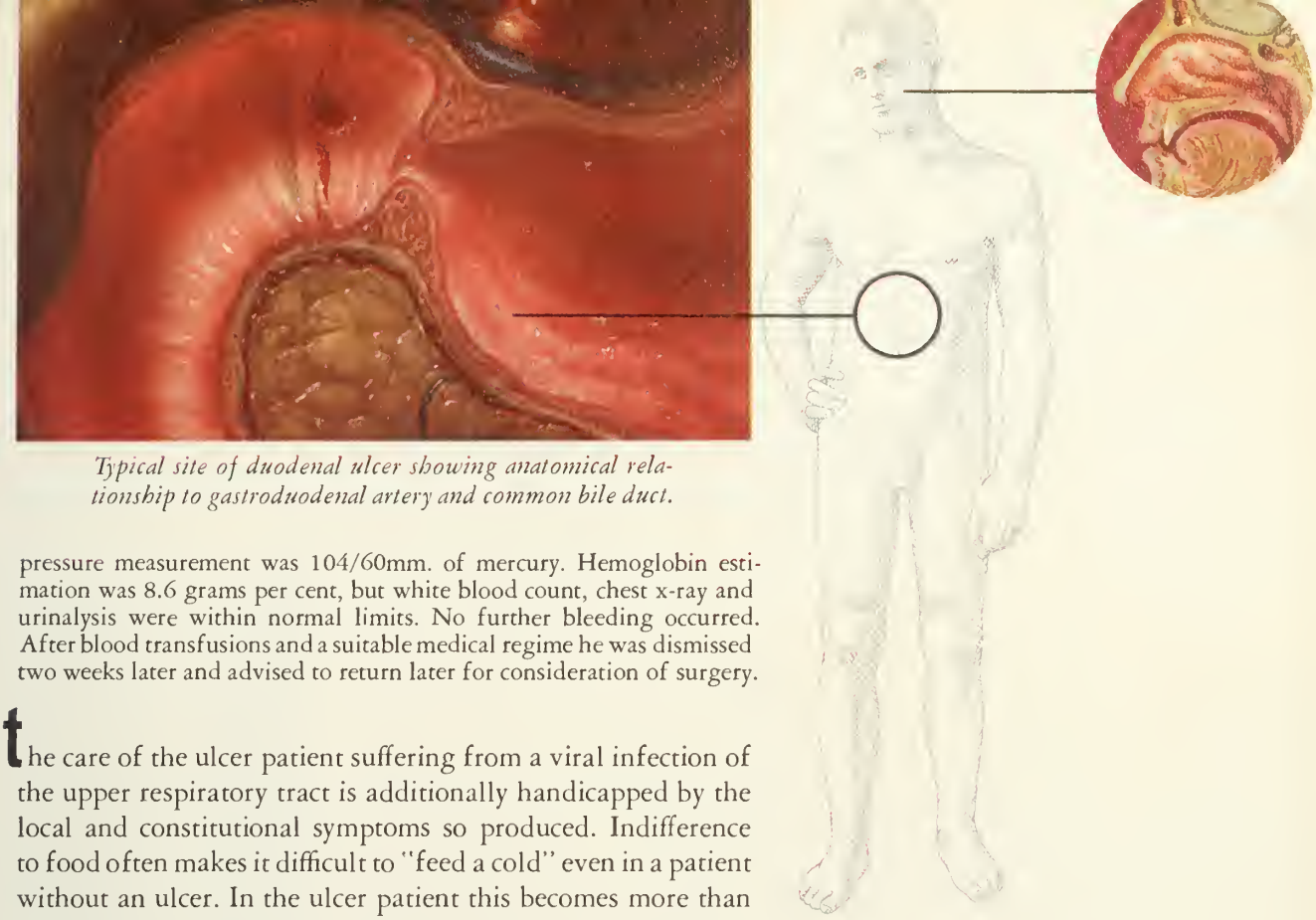
Case report A 48 year old white male executive, suffering from hematemesis and melena for 12 hours was admitted to hospital on April 8, 1965. He gave a history of duodenal ulcer proved by x-ray studies 23 years previously. In the intervening years he suffered from typical epigastric pain occurring two hours postprandially, usually for two or three weeks each spring and fall. A hospital admission two years earlier had followed hematemesis of moderate amount.

The present admission was preceded by a recurrence of pain during a period of unusual business pressure. In addition he caught a cold one week before his entry to hospital and his already irregular eating habits were made more so by loss of taste and appetite, blocked nose and general malaise. During the final 36 hours he used aspirin to relieve his cold, taking 2 or 3 tablets with a glass of water on 6 or 7 occasions. Before retiring he drank a glass of hot toddy.

He awakened about 1 a.m. and vomited dark red blood and recently ingested food mixed with whisky. Melena followed and he was transferred to hospital. On admission he was pale, cold and sweating. Apart from epigastric tenderness and black stool on the examining finger after rectal examination, his general physical examination was not remarkable. Temperature was normal, pulse was thin and thready with a rate of 114 beats per minute, and blood



The commonly found "clover-leaf" roentgenographic abnormality of chronic duodenal ulcer due to spastic contractions and scarring.



Typical site of duodenal ulcer showing anatomical relationship to gastroduodenal artery and common bile duct.

pressure measurement was 104/60mm. of mercury. Hemoglobin estimation was 8.6 grams per cent, but white blood count, chest x-ray and urinalysis were within normal limits. No further bleeding occurred. After blood transfusions and a suitable medical regime he was dismissed two weeks later and advised to return later for consideration of surgery.

The care of the ulcer patient suffering from a viral infection of the upper respiratory tract is additionally handicapped by the local and constitutional symptoms so produced. Indifference to food often makes it difficult to "feed a cold" even in a patient without an ulcer. In the ulcer patient this becomes more than a homily, for malaise and apathy towards irksome routine produce a lack of interest in adhering to an ulcer program and result in its eventual failure if these symptoms are not relieved. The absence of curative treatment for these viral infections has spawned many a strange therapeutic offspring and some of the more generally accepted remedies contain a special risk for the ulcer patient.

To the gastric physiologist, the shot heard around the world was not fired at Concord but was discharged through the stomach of Alexis St. Martin. The worthy voyageur had a more than modest thirst and on several occasions William Beaumont observed through the resulting fistula the changes of gastritis which followed an immoderate ingestion of alcohol.[3] It is now well known that alcohol stimulates the production of gastric juice and the patient with an ulcer, even in remission, should not drink alcohol without first taking food, milk or antacid. The use of various alcoholic remedies for the common cold is to be strongly discouraged in this type of patient. Factors already present can produce an acute exacerbation of ulcer symptoms without the added stimulus of alcohol.

Headache and facial pain, sore throat and generalized aching are subjective discomforts of viral infections of the upper respiratory tract or their complications. Relief from them is usually sought in the family medicine cabinet, and of all the medications habitually stored there, salicylates are the most frequently used. Oral ingestion of salicylates has produced



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(Advertisement)



substernal pyrosis and sometimes epigastric pain in susceptible individuals. Bleeding from erosions of the gastric mucosa has followed their use and has been severe enough in some instances to cause hematemesis and melena.[4] It has been suggested that interference with the protective mucous layer of the stomach allows this to happen. There is no evidence that hypersecretion occurs, but the taking of aspirin has been followed by exacerbation of ulcer symptoms and occasionally by gastrointestinal bleeding.[5] The ulcer patient with a cold should take salicylates with an antacid, or preferably other means of symptomatic relief should be found.

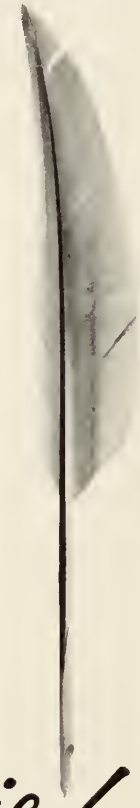
Caffeine has two actions on gastric secretion. One directly stimulates production of acid and the other potentiates the out-pouring of gastric juice as a response to other stimuli.[6] In high doses to animals, it has produced erosive gastritis and peptic ulceration. Caffeine-containing beverages are discouraged for the ulcer subject and forbidden during an acute exacerbation.[7] Many cold remedies contain caffeine.

To sufferers from allergic rhinitis springtime brings symptoms of nasal obstruction, loss of taste and smell and malaise similar to those caused by viral infection but due instead to allergens which at that time of year are principally tree pollens. Relief from these symptoms can be obtained, though not wisely, by the use of steroid medication. Unfortunately, chronic sufferers from these allergies have used this approach with varying degrees of success. Steroid hormones increase gastric secretion and delay the healing of experimental ulcers.[8,9] Clinically their administration has been associated with reactivation of healed duodenal ulcers, and with bleeding and perforation which were not always preceded by typical ulcer distress. Because of these harmful effects, their use in the ulcer patient is best avoided for other than serious medical problems and then only with adequate antacid coverage.

Summing up It is immaterial by which pathways the malaise and lassitude, depression and irritability activate an ulcer, but it is the physician's responsibility to ensure that the medications he selects to relieve the symptoms of a cold do not further aggravate the ulcer.

References 1. Divertie, M. B. and Brown, A. L., Jr.: The Pulmonary Alveolar Macrophage. Med. Clin. N. Amer. 48:1049-1054, July, 1964. 2. Emery, E. S., Jr. and Monroe, R. T.: Peptic Ulcer: Nature and Treatment Based on a Study of 1,435 Cases. Arch. Int. Med. 55:271, 1935. 3. Osler, W.: Experiments and Observations on the Gastric Juice and the Physiology of Digestion by William Beaumont, M. D. XIII Internat. Physiol. Congress. Boston, Massachusetts. pp. 280, 1929. 4. Leonards, J. R.: Aspirin and Blood Loss From the Gastrointestinal Tract. Fed. Proc. 21:452, 1962. 5. Kossover, M. F. and Kaplan, M. H.: The Role of Salicylates in Massive Gastrointestinal Hemorrhage. Am. J. Gastroenterology. 35:445-455, 1961. 6. Roth, J. A. and Ivy, A. C.: Synergistic Effect of Caffeine on Histaminic Response. Am. J. Physiol. 142:107, 1944. 7. Musick, V. A., Avey, A. T., Hopps, H. C. and Hellbaum, A. A.: Gastric Secretion in Duodenal Ulcer in Remission; Response to the Caffeine Test Meal. Gastroenterology. 7:332, 1946. 8. Kahn, D. S., Phillips, M. J. and Skoryna, S. C.: Healed Experimental Gastric Ulcer in the Rat; Re-Ulceration Resulting from Cortisone Administration. Amer. J. Path. 38:177-187, 1961. 9. Chaikof, L., Janke, W., Pesaros, P. C., Ponka, J. L. and Bush B. E.: Effects of Prednisone and ACTH on Gastric Secretion. Arch. Surg. 83:32-39, 1961.

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GUEST EDITORIAL

(Continued from Page 878)

such ruthless men as Bismark and Hitler so interested in the well-being of their subjects? Evidently more than humanitarianism was at stake. It appears that all dictators—communist, fascist, or disguised—have at least one thing in common. They all believe in Social Security, especially in coercing people in governmentalized medicine.

"Ever since Bismark, the great dictators and little demagogues compete with one another and with the humanitarians in courting the favor of the ailing, the lame, the blind, the poor, the under-privileged and the aged. Today British and French vie with each other in eulogizing their respective security plans. But Stalin out did them all. He stated that 'Government insurance in the USSR is a source of pride of the Soviet workers before the whole world.' It is one of the jewels in the colossal edifice of Socialism.

"The great French visionary, Alexis de Tocqueville (De la Democratic en Amereque, 1840), warned more than a century ago that democracies like ours may succumb to a new and soft technique of governmental benevolence that subdues all individuality."

Let us hope that history does not repeat itself here.

(Reprinted from St. Louis Medicine, February, 1966)

SEX HORMONES AND EPILEPSY: ARE THEY RELATED?

University of California scientists are looking into the possibility that sex hormones and other hormones play a role in triggering the onset of sleep and epileptic seizures.

According to Dr. Gunnar Heuser and his associates at UCLA, there are many other factors involved in both states, but the role of hormones has never been thoroughly studied.

Dr. Heuser says animal studies have shown that some hormones cause a sleep-like sedation or long-lasting epileptic activity when given in large amounts. The UCLA researchers think the human brain may be more sensitive to hormonal activity than experimental animals and so might react to the amounts already present in the body.

Dr. Heuser pointed out that there may not be as great a difference between sleep and epilepsy as was previously believed. He noted the similarities between some petit mal seizures and a momentary "dozing off" state. Likewise, the twitching that occurs during dreaming is not unlike a mild convulsion.

Other factors that may also be related to sleep and epilepsy include the amounts of water and carbon dioxide in the body as well as a person's emotional state at the time of sleep or just prior to a seizure.

ARTHRITIS CONTROL A POSSIBILITY

Progress in the war against chronic diseases is reported by one member of a winning team, the Arthritis Foundation: "The year just ended marks a turning point in man's fight against arthritis. Although the road ahead will have its pitfalls, the question no longer is: 'Can arthritis be controlled?' " The last year has seen a summing up of substantial progress against arthritis, a consolidation of forces, and preparation for a breakout toward final solution. Some arthritic diseases have been brought under control already, and results in 1965 give reason to believe the others will follow, one by one. ("Year of Arthritis," in *Annual Report*/1964-65, The Arthritis Foundation, New York).

"CICERO'S PROGNOSIS"

by

The Honorable Millard F. Caldwell

Justice — Supreme Court

Tallahassee, Florida

The Roman Republic, the foremost power of its day, had reached its zenith. Its leadership had attained unbounded wealth and unstinted power. The rulers were intolerant of restraint, indifferent to the demands of the middle class and contemptuous of the Constitution which was designed to curb their ambitions. The time was some 70 years before the birth of Christ.

Young Marcus Tullius Cicero, then a student of law under old Scaevola, the eminent lawyer of his day, was just about to suffer his first great disillusionment with grasping government. Rome, by force of arms, guile and trickery, dominated the world. Its citizens had grown slick and fat careless of their rights, and had fallen prey to the ruthless politicians who craved more and ever more power and riches.

Young Cicero's first client was a substantial man of business—a man of integrity who trusted his government and his fellow man. But he was a rich man and, because powerful men of government coveted his wealth, he was the victim of bureaucratic chicanery. Young Cicero, retained to plead his cause, submitted documentary proof of his client's innocence to the Judges, confident that justice would prevail.

But, for some reason, his case was not going well. He consulted with his great friend and mentor, Scaevola, telling him what course he had followed and asked why he had failed. Scaevola was disgusted—he slammed the table and, leaning toward Cicero, shouted, "Imbecile! Of what use are records presented to tribunes, consuls or senators if the government is determined to rob and destroy a man who had displeased them, or who possesses what they want? Have I truly wasted all these years on such an idiot as this Marcus Tullius Cicero!"

Does that have a familiar ring of 1965 and the current raids of government on your substance and your rights?

Nevertheless, Cicero, before the august Senate, pleaded his client's defense against confiscatory taxation, saying "we are taxed in our bread and our wine, in our incomes and our investments, on our land and on our property, not only for base creatures who do not deserve the name of man, but for foreign nations, for complacent nations who will bow to us and accept our largesse and promise us to assist in the keeping of the peace—these mendicant nations who will destroy us when we show a moment of weakness or our treasury is bare, and surely it is becoming bare. We are taxed to maintain legions on their soil, in the name of law and order and the Pax Romana, a document which will fall into dust when it pleases our allies and our vassals. We keep them in precarious balance only with our gold. Is the heart-blood of our nation worth these? Shall one Italian be sacrificed for Britain, for Gaul, for Egypt, for India, even for Greece, and a score of other nations? Were they bound to us with ties of love, they would not ask our gold. They would ask only our laws. They take our very flesh, and they hate and despise us. And who shall say we are worthy of more?"

Does that sound like 1965 and the billions we are pouring out to such as Nasser and Tito and their ilk?

(Continued on Next Page)

Presented at the 22nd Annual Meeting of the Association of American Physicians and Surgeons, October 7, 8 and 9, 1965, Columbus, Ohio.

Cicero did not save his client. But he did live to argue the cause of honest government and to talk with Sulla, the Dictator, about integrity and fair dealing. Sulla had little faith in the people. He believed them too deeply interested in their own welfare to concern themselves, too timid to stand up for their rights. He told Cicero the middle class, the lawyers, the physicians, the bankers and the merchants would make no sacrifices. He said none of your lawyers will challenge the lawmakers and cry to them, "This is unconstitutional, an affront to a free people, and it must not pass!" He asked "Will one of these, your own, lift his eyes from his ledgers long enough to scan the Twelve Tables of Roman Law, and then expose those who violate them and help to remove them from power, even if it costs their lives? These fat men. Will six of them in this city, disregarding personal safety, rise up from their offices and stand in the Forum, and tell the people the inevitable fate of Rome unless they return to virtue and thrift and drive from the Senate the evil men who have corrupted them for the power they have to bestow?"

Does that sound like 1965 and our indifference to government? Does it remind you of our preoccupation with our personal affairs and our unwillingness to "rock the boat?"

Rome continued to decay. The ambitious were fattening upon its bones. The liberties of the people were lifted one by one in the name of emergencies or traded in on benefits. Catiline, brilliant, uninhibited and evil, was pressing his suit for leadership and, in his course, curtailing the rights of all those who disagreed.

Cicero, in his Second Oration before the Senate, had this to say: "Too long have we said to ourselves 'Intolerance of another's politics is barbarous and not to be countenanced in a civilized country. Are we not free? Shall a man be denied his right to speak under the law which established that right?' I tell you that freedom does not mean the freedom to exploit law in order to destroy it! It is not freedom which permits the Trojan Horse to be wheeled within the gates * * *. He who is not for Rome and Roman Law and Roman liberty is against Rome. He who espouses tyranny and oppression and the old dead despotisms is against Rome. He who plots against established authority and incites the populace to violence is against Rome. He cannot ride two horses at the same time. We cannot be for lawful ordinances and for an alien conspiracy at one and the same moment."

Does that sound like 1965 and its government sponsored demonstrations?

Cicero continued: "Though liberty is established by law, we must be vigilant, for liberty to enslave us is always present under that very liberty. Our Constitution speaks of the 'general welfare of the people.' Under that phrase all sorts of excesses can be employed by lusting tyrants to make us bondsmen." Does that sound like 1965 and the usurpation by the Supreme Court in the name of "the general welfare?"

As the years went by Cicero continued his struggle, he became Consul and, for a time, stopped waste and thievery. But the people again grew careless, weary of well doing, and the avaricious and the corrupt politicians moved in and sought to banish Cicero. Once again he appeared before the Senate, but this time to plead his own cause. He said "The Senate, in truth, has no right to censure me for anything, for I did but my duty and exposed traitors and treason against the State. If that is a crime, then I am indeed a criminal."

Crassus, Caesar and Pompey were present. He turned and looked at them, but their faces were shut against him. His smile was sad as he said to them, "You have succeeded against me. Be it as you will. I will depart * * *." He then told the Senate: "For this day's work, lords, you have encouraged t r e a s o n and opened the prison doors to free the traitors. A nation can survive its fools, and even the ambitious. But it cannot survive treason from within. An enemy at the gates is less formidable, for he is known and he carries his

(Continued on Page 888)

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Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

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Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.



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(Continued from Page 885)

banners openly against the city. But the traitor moves among those within the gates freely, his sly whispers rustling through all the alleys, heard in the very halls of government itself. For the traitor appears no traitor; he speaks in the accents familiar to his victims, and he wears their face and their garments, and he appeals to the baseness that lies deep in the hearts of all men. He rots the soul of a nation; he works secretly and unknown in the night to undermine the pillars of a city; he infects the body politic so that it can no longer resist. A murderer is less to be feared. The traitor is the carrier of the plague. You have unbarred the gates of Rome to him."

Does that sound like 1965 and the subversives in high places who have been exposed and those who are suspect but not yet exposed?

Cicero was exiled from Rome but not from his conscience. He continued to plead the cause of honest government. But the people he pleaded for were not concerned. His friends, the lawyers, the doctors and the business men told him "We do not meddle in politics. Rome is prosperous and at peace. We have our villas in Caprae, our racing vessels, our houses, our servants, our pretty mistresses, and our comfort and treasures. We implore you, Cicero, do not disturb us with your lamentations of disaster. Rome is on the march to the mighty society, for all Romans."

Does that sound like 1965 and some of the people you know and meet in your day to day walks of life?

Cicero was in despair. He began to write his book *De Legibus* but Atticus, his publisher, asked, "But who will read it? Romans care nothing for law any longer, their bellies are too full."

And then, later, Brutus, the long time sycophant of the ambitious Caesar, came to his senses and went to Cicero with his plea that something be done to save the nation. He confessed his error, he said he had believed in Caesar, he had believed he would restore the republic but that he has betrayed his trust.

Cicero's bitter reply was "Do not blame Caesar, blame the people of Rome who have so enthusiastically acclaimed and adored him and rejoiced in their loss of freedom and danced in his path and gave him triumphal processions and laughed delightedly at his licentiousness, and thought it very superior of him to acquire vast amounts of gold illicitly. Blame the people who hail him when he speaks in the Forum of the 'new, wonderful good society' which shall now be Rome's interpreted to mean 'more money, more ease, more security, more living fatly at the expense of the industrious.' Julius was always an ambitious villain, but he is only one man."

Does that talk of a 'wonderful good society' remind you of 1965 and its "Great Society?"

I am not sure just where this country is going nor what life in America will be like five, ten or fifty years from now. But it's clear that the old ideas of obedience to law, public thrift and common honesty, the old laws of supply and demand and the old concepts of local self-government and individual responsibility have been discarded.

And it staggers the imagination to contemplate the changes which have occurred in the last thirty years. Our manner of government and our way of life are, for the United States, new and novel, with little in common with what has gone before. Our forefathers would be astounded by the insidious encroachments of centralized government in our every day life.

Government is in the business of housing the people, in prescribing the hours we can work, with whom we must work, the salaries we are paid and the tax to be withheld from that salary, the schools our children can go to and with whom they must sit and play, the highways we can drive on, how and where our food is grown and processed. The government concerns itself with the products you buy, the conditions under which they are manufactured, the manner in which they are

(Continued on Page 890)

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advertised, the kind, the shape and the size of the package in which they are offered and how they are labeled. It is meddling with your health, your general welfare, your old age and your retirement, your security after retirement, your savings and the banks in which you place your savings, the conduct of your city, its police department and its department of health; the conduct of the affairs of your state, its law enforcement, its elections, the composition of its legislature and every other facet of your life, private and public.

But the people of this country may like all this—to say the least, they have asked for it. They have elected the public officials who brought it about and they sit around with their tin cups waiting for more. If that's what a majority of the people of this nation want, those of us who disagree can't complain. The majority has the right to change our form of government if it wishes.

But one unfortunate aspect is that, once the die is finally cast, it will be too late to change our minds; it's altogether unlikely we could then ever re-establish the kind of government, the kind of independence and individuality our forefathers conceived and anticipated for posterity. We will have come too far and given up too much.

For that reason it is important that we give some thought to what is happening and reach some conclusions about what we'd like our future to be. We must count the cost of all the politically inspired humanitarian claptrap and be sure we're willing to pay the price in freedom, liberty and independence.

The cause of sound government is not without a feeble hope. There is an overriding suspicion and uneasiness. The taxpayers complain of the complexities and the inequities fostered by internal revenue; the farmers complain of regimentation; the lawyers complain of the federal judiciary and its whimsical construction of the Constitution; the police deplore the judicial pampering of the criminals; citizens generally are alarmed by the government stirring up of the caldrons of racial hate; students of government seeking the truth are handicapped by managed news and the dominance of news media by the extreme liberals; many are apprehensive of the coddling of communists in high office and the people generally resent America's subordination to the United Nations and the waste of multiple billions on red satellites.

Well, we ask, in the light of the precarious situation what can we do? The first thing to decide is whether we want to live in a constitutional Republic or under a socialistic despotism. Theoretically, I suppose the vast majority would say they prefer constitutional government but, as a matter of truth, that same majority is unwilling to jeopardize the spurious but temporary prosperity linked to current socialistic practice. Indeed, it may be we are irrevocably committed—too many of us have sold the future for the hope of free medical care, free college education, social equality and security against poverty.

But, if you are concerned, I suggest you assess the responsibility for what's happening in government. If you are honest with yourselves you will admit we cannot blame the weak Congress or the bureaucrats, the tax gatherers or the judges or the communists—the responsibility must rest upon our own shoulders.

And while it's painfully obvious that our conduct of public affairs, under both political parties has long been lacking in the forthrightness and courage so essential to our independence, we cannot take the easy way out and charge the nation's ills to the ADA, the Bobby Bakers, or the Supreme Court. To put it very simply, you and I and the people generally have been negligent in attention to our public business.

In good conscience, we cannot say the federal encroachments upon our rights and the rights of the states have come with any surprise. We have been warned and warned again. Two thousand years ago Cicero told us what to expect. When our ancestors were

(Continued on Page 895)



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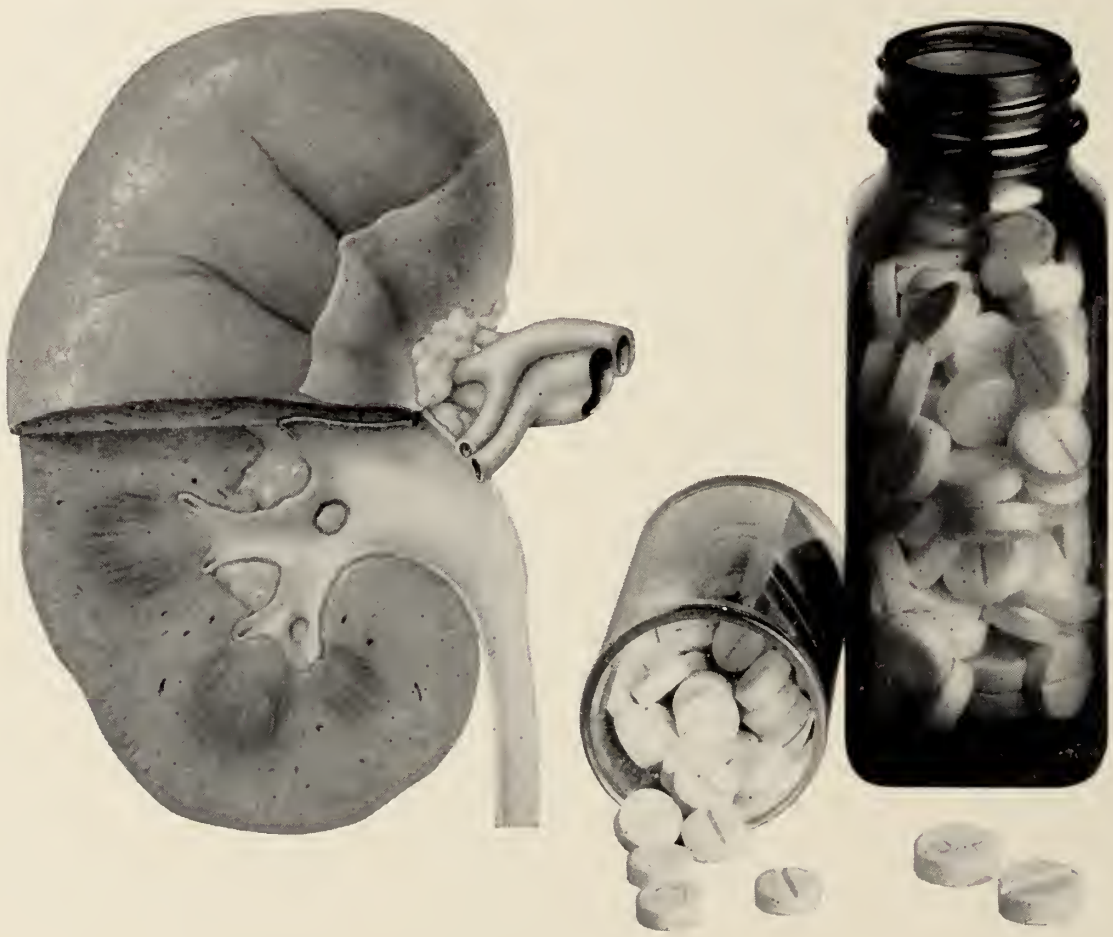
REFERENCES: 1. Vollmer, H.: Arch. Neurol. and Psychiat., 43:1057, 1940. 2. Morrissey, J.H.: J. Urology, 57:635, 1947. 3. Krantz, J.C., Jr., and Carr, C.J.: Pharmacological Principles of Medical Practice, 2nd ed., Baltimore (1954), 552.

*This one at Westover, elegant Colonial Virginia plantation, located on the James River near Richmond. Built in the early 1730's by William Byrd II, founder of Richmond, it is now the home of Mrs. Bruce Crane Fisher.

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where today's theory is tomorrow's therapy

(Continued from Page 890)

considering the adoption of the Federal Constitution for the new Republic, Patrick Henry distrusting a central government, with true and unerring foresight, told the people to "be extremely cautious, watchful, jealous of your liberty. Instead of securing your rights, you may lose them forever." He said, "there will be no checks, no real balances in this government," and looking ahead to 1965, he said "this government will * * * destroy the state government and swallow the liberties of the people."

George Mason was fearful of centralization and thought there was a very real danger of losing all the Revolution had gained. He said that a consolidated government "is totally subversive of every principle which has hitherto governed us."

William Grayson was suspicious of the proposed Supreme Court. He said, "this court has more power than any court under heaven * * *." George Mason agreed and said the creation of the court would result in the destruction of state governments because, in the absence of restraint, the court "will be the judges of how far their law will operate."

Benjamin Franklin, after the Constitution was adopted, anticipating a people negligent in safe-guarding their rights, said he thought our government would be well administered for a few years but that it "can only end in despotism."

At the conclusion of his two terms as President and in the light of his experience, George Washington thought the people of the future should be warned of the dangers inherent in an unrestrained Supreme Court—he said: "If * * * the distribution * * * of the constitutional powers be in any particular wrong, let it be corrected by an amendment in the way which the Constitution designates. But let there be no change by usurpation; for though this, in one instance, may be the instrument of good, it is the customary weapon by which free governments are destroyed."

Thomas Jefferson foresaw the evils of judicial encroachment when, in effect, he said the Court, under its philosophy, made the Constitution a mere thing of wax to be twisted into any form they pleased; that to consider the Judges the ultimate arbiter of the Constitution would place us under the despotism of an oligarchy.

Some years later Lord Macauley, the English historian, after a careful study of our government in general and our Constitution in particular warned the American people "Your Constitution is all sail and no anchor. Either Caesar or Napoleon will seize the reins of government with a strong hand, or your Republic will be as fearfully plundered and laid waste by the barbarians in the twentieth century, as the Roman Empire was in the fifth—with this difference, that the Huns and Vandals who ravaged the Roman Empire came from without, and your Huns and Vandals will have been engendered within your own country by your own institutions." It is reasonable to assume he thought the Supreme Court was one of the institutions which would destroy us from within.

Abraham Lincoln thought it necessary to tell the people: "If the policy of the government upon vital questions affecting the whole people is to be irrevocably fixed by the decisions of the Supreme Court the people will have ceased to be their own rulers, having to that extent practically resigned their government into the hands of that eminent tribunal."

Robert Moses had this to say the other day: "We are living in a second American Revolution, as critical as the first one which established our nation * * * the Supreme Court now legislates and executes * * * It now bypasses the state courts and delegates to lower federal courts authority to tell the states what to do and how to do it * * * the states are reduced to peonage * * * until we change our Constitution, any five judges out of nine —distinguished men no doubt but political accidents not chosen by the people—are ruling the country and determining its future."

No, we cannot have been surprised by what

(Continued on Page 898)

"A DRAMATIC INCREASE IN SALMONELLOSIS HAS BEEN OBSERVED

SALMONELLA CARRIERS "PRESENT A FORMIDABLE FIFTH COLUMN."[2]

Furoxone exerts "outstanding activity against Salmonella sp."[3] and "has enhanced the physicians' armamentarium in that it now affords a relatively effective, safe bactericidal agent, which may be used to treat the active disease as well as the carrier state".[2]

SALMONELLA SPECIFIC

FUROXONE®

FURAZOLIDONE LIQUID/TABLETS

Often succeeds where others fail in a wide variety of bacterial diarrheas. Specifically within the broad bactericidal range of Furoxone:

Salmonella paratyphi	Salmonella montevideo
Salmonella schottmülleri	Salmonella newport
Salmonella typhimurium	Salmonella anatum
Salmonella choleraesuis	Salmonella derby
Salmonella enteritidis	

Proper antibacterial therapy for individual cases should help in reducing the total number of cases in an epidemic situation.

Side effects are infrequent. A few hypersensitivity reactions to Furoxone have been reported including a fall in blood pressure, urticaria, fever, arthralgia and a vesicular or morbilliform rash. These reactions subsided promptly following withdrawal of the drug. Primaquine-sensitive patients may develop a mild reversible hemolytic anemia. Nausea, emesis, headache or malaise may occur occasionally. To obviate alcohol-disulfiram type reactions, advise against use of alcohol-containing drugs during therapy and four days thereafter.

Do not give to infants under one month of age.

Composition: Furoxone Liquid contains, per 15 cc. tablespoonful, furazolidone 50 mg., pectin 225 mg., and kaolin 3.0 Gm. Furoxone Tablets each contain 100 mg. of furazolidone.

References: 1. Editorial: J.A.M.A. *189*:691 (Aug. 31) 1964. 2. Foertsch, J. H.: J. Oklahoma Med. Assn. *57*:449 (Oct.) 1964. 3. Paul, H. E., and Paul, M. F.: The Nitrofurans—Chemotherapeutic Properties, in Schnitzer, R. J., and Hawking, F. (Eds.) Experimental Chemotherapy, Vol. 2, New York, Academic Press, 1964.

Originatora and Developera of The Nitrofurans
EATON LABORATORIES
Division of The Norwich Pharmacal Company
NORWICH, NEW YORK

(Continued from Page 895)

has happened because, from our earliest days, we have been on notice it would happen. We, very simply, have refused to heed the warnings or to acknowledge that our freedoms can be preserved by vigilant action and not otherwise. We have refused to acknowledge that bad government and bad public officials are but the reflection of ourselves as we have cast our votes—that the elected official is nothing more nor less than the instrumentality through which we express our will.

The whole trouble is that, in our civic stupor, we have forgotten that major policies, whether the gift of our substance to the communists or the regimentation of industry, agriculture, business and the professions, require either the approval or acquiescence of the citizens of this country. What has been done, both that which has contributed to our stability and that which has endangered our future, has been with our consent. But I should tell you that the time is growing short. We must make a choice between the form of government conceived by those who captured our freedoms from Great Britain in the Revolution and this new form of government, a centralization, advocated and practiced by the left-dealers. Whether this nation is to be governed by the rule of law, under the Constitution, or the rule of man, unfettered by any restraint, constitutes the most vital problem of our time.

It is no longer of first importance whether we collectivize the professions or bankrupt the nation in abolishing poverty or in supporting our enemies abroad—the vital question, the question, in the face of which all others fade to insignificance, is whether we save the Constitution of the United States and the Republican form of government established by it.

If we can succeed in that respect and retain the right to elect the Congress and the President, all of us, the timid and the brave, the generous and the greedy, the conservatives, the liberals, and the middle gender moderates, can live with wisdom and folly, frugality and waste, the ADA socialists and the crafty politicians. But, and never forget it, we cannot exist as a free people nor our nation as a Republic without a Constitution, observed in fact and not in the breach.

Whether the nation moves even further to the left as a socialistic despotism or is reestablished as a Republic depends entirely upon the will of the majority. The answer does not hang upon whether you are liberal or conservative, a Democrat or a Republican —the answer, the sole answer, is whether you believe in and are resolute in trying to save the Constitution—as it was written and intended—upon whether you are determined to elect public officials who believe in that Constitution and are willing to boot them out of office without ceremony if they falter in their conviction.

You must face the fact that we have spent thirty years setting up the machinery to destroy that Constitution and it will take dogged determination and constant, unwavering purpose to save it. You will have to reckon with the human inclination to avoid unpleasant facts. We are reluctant to admit our conversion to socialism or that the Supreme Court has usurped the rights of the Congress to legislate.

But we must admit that many people, many splinter groups, approve one or the other of the encroachments by the Supreme Court upon the rights of the majority. The Negroes are happy in the belief that the Brown decision established superior rights for them over the majority; the criminals are happy with the Mallory and Escobedo decisions because of the great advantage gained over the law enforcement officers and society in general; the communists thoroughly approve the Schware, Konigsberg and the Slochower cases which insure their right to infiltrate the legal profession and the schools. The labor unions like the decisions which gave to them enormous advantages. The urban politicians like the reapportionment decisions which insure their control of the state houses and the Congress.

Some of the changes made in the Constitution by judicial fiat were useful. Some, I

would actively support in the political arena, but, as George Washington advised us, they should come in the manner prescribed by the Constitution and not through the unconstitutional usurpation by a court not subject to the vote of the people.

But you must remember that, by coddling particular self-interest groups, one after the other, the "rule by man" forces have built a strong following—a following which is active, vocal and organized.

The devotees of the "rule by man" theory include the moderate, the ADAers, most of labor, practically all of the minorities, many ministers and many of the business and professional world. But I do not believe the tin cup crowd constitutes a majority of the people of this country.

The simple majority, and I emphasize the word simple, composed of decent, ordinary businessmen, doctors, farmers, mechanics, preachers, and just people, does not realize how it has been duped. The honest fellow has always been an easy mark—the easiest to rob.

The simple majority is slow to anger, they are not given to sit-downs and sit-ins, to placards and to violence and to hate. But neither is that majority watchful of its own rights and the freedoms it inherited from brave ancestors. The majority is slow to express its opinion—slow to write the Congressmen or the President or the Supreme Court or the newspaper; it is, because of its supinely acquiescent attitude, slow to stand up and be counted.

If you, per chance, are among those who would rather be governed by constitutional law than by the whims of men unfettered by restraint I suggest that the war will have to be fought on a wide front. You can't win with brush fights in special area. You must join and coordinate your efforts with the professions, with business and industry, with

(Continued on Page 900)



for psychiatric treatment

Peachtree Hospital, located in Atlanta, Georgia, is a complete psychiatric, alcoholic and drug addiction treatment facility accredited by the Joint Commission on Accreditation of Hospitals ☐ The hospital has 65 beds, 47 of which are devoted to the care of psychiatric patients and 18 of which, in a separate area, are for patients with acute cases of chronic alcoholism or drug addiction ☐ Treatment procedures include psychotherapy, electroconvulsive shock therapy, subinsulin coma and chemotherapy ☐ *We will be pleased to provide further information upon request.*

ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

peachtree hospital

41 PEACHTREE PLACE, N. E. / TELEPHONE 873-5681 / ATLANTA 9, GEORGIA

(Continued from Page 899)

agriculture and all facets of American society concerned with the preservation of personal liberty. The centralizers can lick the isolated groups but they could not defeat a sustained drive by the consolidated believers in constitutional government.

As a conservative, you should scrutinize every political candidate, at whatever level, and support the man who believes in our traditional form of government. You should examine every major governmental proposal and express your convictions at the ballot box and by letter, telegram and in person. You should devote the same degree of thought and attention to your public business as you give to your personal affairs.

If you are a liberal, you should insist upon a Republican form of government. You should oppose every invalid executive order and shout from the housetops against the Supreme Court of the United States every time it arrogates to itself the power to write new law and to rewrite the Federal Constitution. You should remember that the historic method of stamping out liberalism is to undermine constitutional government and substitute the rule of man. You should remember that in Russia and Germany, in Italy and Red China, the liberals were promised more liberality and more freedoms—that the promisors promised fast action by fiat. They said, as our Supreme Court now says, let's do these good things now—let's not wait for the slow processes of the law.

If you are an ADA left-winger, you should insist upon utopia under the law, not by executive order. You should insist upon the right to live in Mr. Gotrock's house on the beach, the right to a free college education for your children, your right as a protestant to join the Knights of Columbus—but you should never give Big Brother the power to confer those rights by ukase. Why? Because when the President or the Supreme Court usurps the power to give you something to which, under the law, you are not entitled, the President or the Court can, with equal ease, usurp the power to take from you that to which you are entitled.

If you are one of the American minorities and unhappy with your race, you should exert every effort to improve your position; you can aspire to the social organizations of the other races and endeavor to pull down distinction and level off all differences. But, being knowledgeable in history, you should do all these things under constitutional law. You ought never urge the illegal use of the army in your behalf because, when you have lost your popularity as a cause and are no longer needed at the ballot box, the President can use that same army illegally against you. You should remember vividly, how, in other countries, where constitutional government was abolished, minorities were cooked in the gas ovens or deep frozen in Siberia.

And if I were a left-wing newspaperman wedded to socialism, hating wealth and the wealthy, I would do my writing behind America's constitutional guaranty of free speech. I would emulate the feist dog and bark mightily, but from behind the strong fence of constitutional protection. I would remember only too well how freedom of the press and freedom of those who write for the press have been curtailed in those countries where man has risen above the law. Each morning I would remind myself to remind all my left-wing doctors, preachers, teachers and racist friends that only under a constitutional form of government, where the rights of the individuals are protected, can we live and breathe and preach and write our thoughts; that under centralized power our only free choice will be to write and preach and teach as Big Brother tells us or to go dig salt in the mines.

But what would you do if your aim is for a dictatorship or a communistic take over? How would you go about weakening the fiber of the country? You would know that, given a fair choice between a representative Republic and a dictatorship, the vast majority of the people in this country would vote against centralization.

No, your road to successful take over would

NEWSLETTER

MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

A single, easy-to-complete form for older people and physicians to use in requesting payment for medical services under the medicare program has just been announced by Robert M. Ball, Commissioner of Social Security.

The one-page form was developed in close cooperation with representatives of the American Medical Association's Council on Medical Services. It has also been approved by the Health Insurance Council, a body representing the health insurance industry. The form was discussed and recommended for adoption by the Health Insurance Benefits Advisory Council, a group appointed under the law to advise the Social Security Administration on administrative policies and regulations. Nine of the 16 members of the Advisory Council are physicians.

There will be two ways to claim payment for medical services. Under one method, the doctor will bill the patient, and after the patient has paid the bill, the patient will claim reimbursement from the intermediary. Under the other method, if the doctor and patient agree, the doctor will send in the claim and receive payment.

Under the payment-to-patient-method, the patient will fill in the upper half of the form and attach the itemized receipted doctor bills. He will need to ask the doctor to fill out the lower part of the form only if the receipted bills do not give sufficient information about the type of services and where and when rendered.

Under the payment-to-doctor-method, the patient will fill in the upper half of the "Request for Payment" form and give the form to the doctor. The doctor will then complete the lower half of the form and mail it to the organization that will be handling medical insurance benefits in that area of the country. This method of requesting payment can be used where all or any part of a medical bill still remains to be paid.

If the latter method is used, the doctor agrees to accept the amount paid to him (over and above the $50 deductible amount) as 80 percent of his total bill, and that he will collect from the patient no more than the remaining 20 percent, plus any part of the $50 deductible still outstanding.

A sample form and a form that the older person can use in making his first claim will be included in "Your Medicare Handbook," a detailed instruction book that will be mailed in June to all persons who are entitled to hospital insurance and medical insurance benefits under the medicare program.
(See back page for reproduction of face of "Request for Payment" form.)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

REQUEST FOR PAYMENT

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

(Type or Print all Information)

Form Approved.
Budget Bureau No. 72-R

Copy from your HEALTH INSURANCE CARD

NAME OF BENEFICIARY *(Patient)*

CLAIM NUMBER

☐ MALE ☐ FEMA

PART I—CLAIMS INFORMATION—TO BE COMPLETED BY PATIENT.

1. Describe the illness or injury for which you received treatment. *(You do not need to complete this item if your doctor completes Part II below)*

2. Was your illness or injury connected with your employment? ☐ YES ☐ NO

3. Are you attaching itemized receipted bills? ☐ YES ☐ NO

4. ASSIGNMENT: Do you want payment for an unpaid bill made directly to the physician or supplier? ☐ YES ☐ NO

AUTHORIZATION: I authorize release of any information required to act on this claim and permit a photographic or other facsimile reproduction of this authorization to be used in place of the original.

REQUEST FOR PAYMENT: I am requesting payment either to myself or to the party accepting my assignment for the medical insurance benefit, if any, payable for the reasonable charges for services or supplies described. Where payment is assigned, I understand I am responsible for the deductible and 20% of the remaining reasonable charges.

5. SIGNATURE *(Patient or authorized representative)*

DATE SIGNED

6. ADDRESS *(Street address, City, State, ZIP Code)*

TELEPHONE NUMBER

PART II—REPORT OF SERVICES—TO BE COMPLETED BY PHYSICIAN—

This Part, Including Physician's Signatur Need Not Be Completed If Paid, Itemiz Bills Are Submitted.

7. A. DATE OF EACH SERVICE	B. PLACE OF SERVICE[1]	C. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	D. NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES *(Diagnosis)*	E. CHARGES	Leave Blank
				$	

8. NAME AND ADDRESS OF PHYSICIAN OR SUPPLIER *(Number and street, City, State, ZIP Code)*

TELEPHONE NUMBER

CODE NO.

9. Total Charges	$
10. Amount Paid	$
11. Any Unpaid Balance Due	$

12. ASSIGNMENT OF PATIENT'S BILL *(See reverse)* ☐ I ACCEPT ASSIGNMENT ☐ I DO NOT ACCEPT ASSIGNMENT

13. SIGNATURE OF PHYSICIAN OR SUPPLIER *(A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)*

☐ MD ☐ DO ☐ DDS OR DMD

DATE SIGNED

[1]O—Doctor's Office IH—Inpatient Hospital ECF—Extended Care Facility OL—Other Locations *(Specify in 7C)*
IL—Independent Laboratory *(give name and address in 7C)* H—Patient's Home OH—Outpatient Hospital NH—Nursing Home

FORM SSA-1490 (4-66)

involve beguiling the people with handouts, creating false sense of security and, step by step, the dishing out of benefits with one hand and the lifting of liberties with the other. You would encourage the issuance of invalid executive orders, all in the name of humanity to please large segments of the voters. You would persuade the judiciary to ignore constitutional restraint and, in the beginning at least, issue invalid decisions in favor of the so-called downtrodden of our population. And, of course, contemporarily, you would have the do-gooders demonstrate and create strife and, in every way possible, debunk and belittle the principles upon which the country grew and prospered and became the first nation of the earth. This prescription, faithfully followed, is likely of success under all conditions and, absent intelligent opposition, can be guaranteed.

These are not just theoretical abstractions —that's the way it's been done throughout history, beginning with Greece and Rome, on down through Russia, Hitler's Germany, Mussolini's Italy and Peron's Argentina.

But there's a great difference in the composition of nationalities. Three or four hundred years ago the English, pushed to the wall by the power spawned rule of the Star Chamber courts, pushed back and recaptured their rights. The Russian people, in sheep like docility, have submitted. The melting pot of America seems content and complacent. It's sycophantic Congress, reflecting public acquiescence, is grovelling at the feet of the President. Its Democratic party has been captured and its Republican party is without policy or guidance. We appear to be drunk on benefits and slogans, rushing lightheartedly along to self-destruction.

(Continued on Page 904)

APPALACHIAN HALL
ESTABLISHED 1916
ASHEVILLE NORTH CAROLINA



An institution for the diagnosis and treatment of psychiatric and neurological illnesses, rest, convalescence, drug and alcohol habituation.

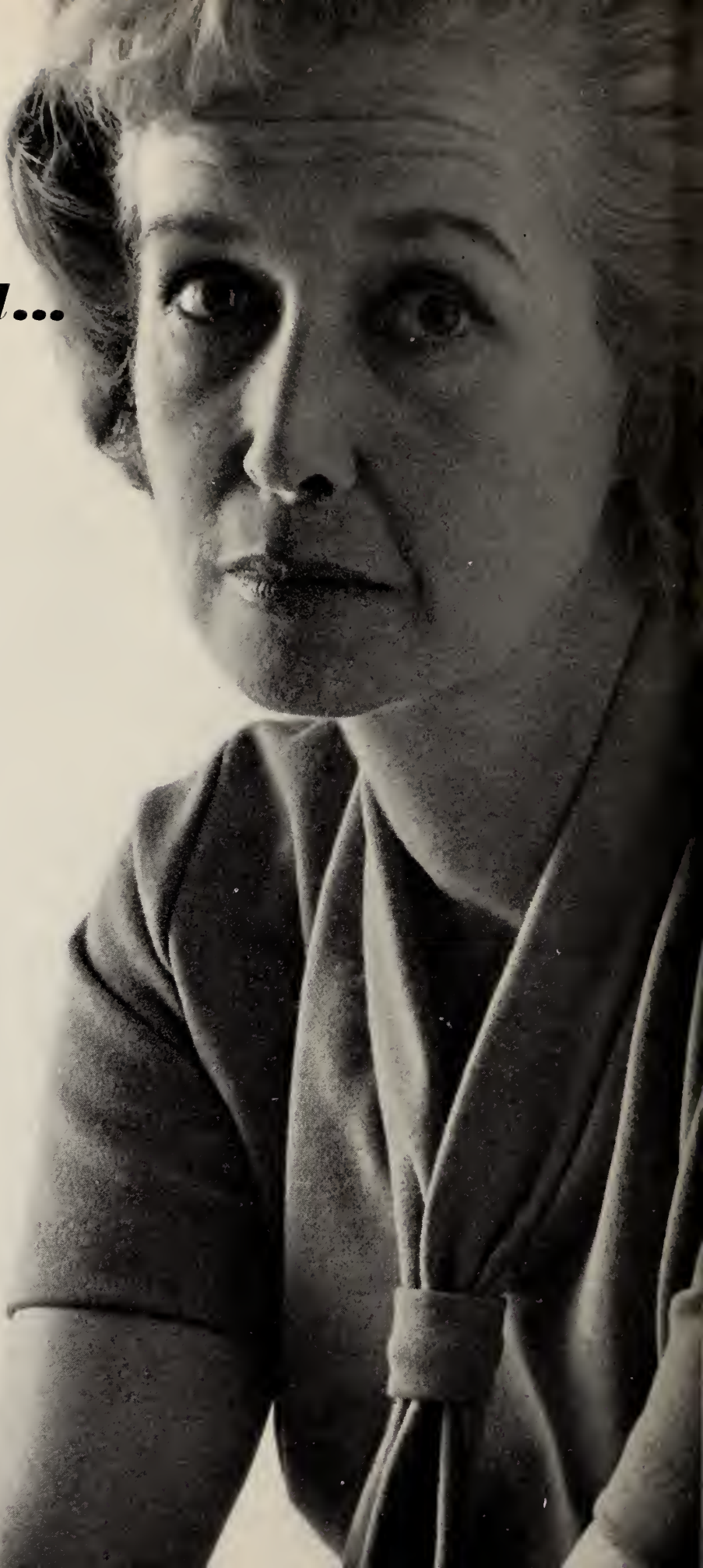
Insulin coma, electroshock and psychotherapy are employed. The institution is equipped with complete laboratory facilities, including electroencephalography and x-ray.

Appalachian Hall is located in Asheville, North Carolina, a resort town, which justly claims an all around climate for health and comfort. There are ample facilities for classification of patients, rooms single or en suite.

Wm. Ray Griffin, Jr., M. D.
Robert A. Griffin, M. D.

Mark A. Griffin, Sr., M. D.
Mark A. Griffin, Jr., M. D.

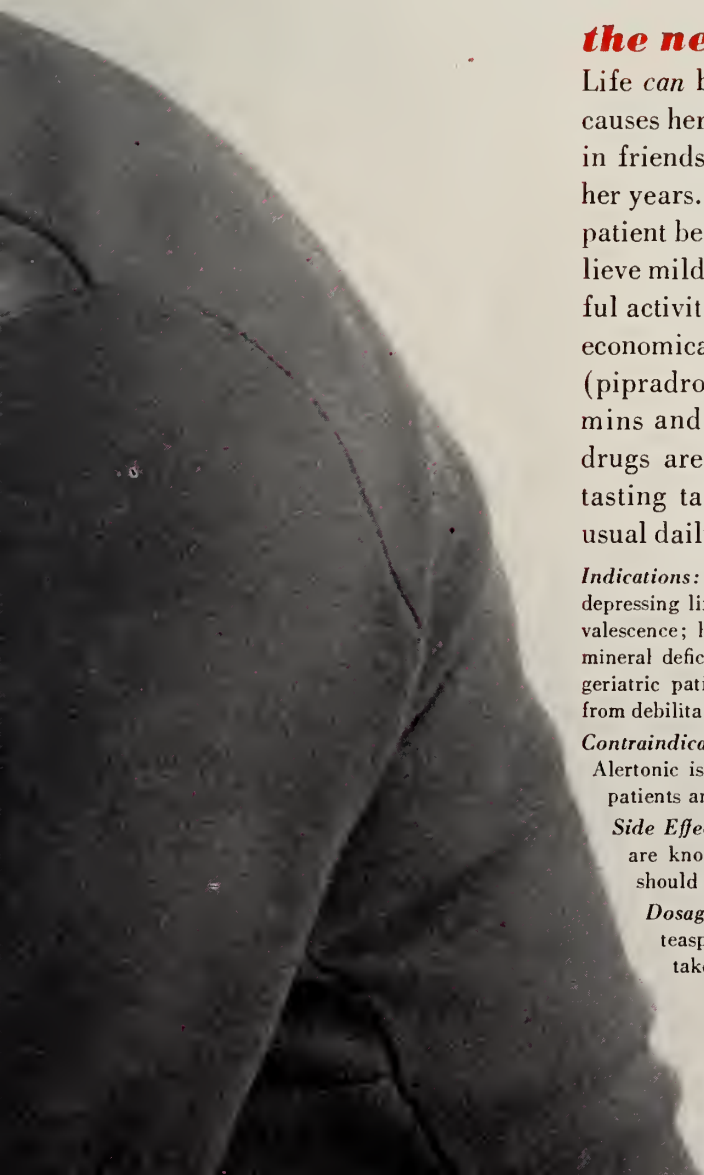
too young
to be so tired...



revive interest...restore activity promptly with Alertonic®

Each 45 cc. (3 tablespoonfuls) contains: alcohol, 15%; pipradrol hydrochloride, 2 mg.; thiamine hydrochloride (vitamin B_1) (10 MDR*), 10 mg.; riboflavin (vitamin B_2) (4 MDR), 5 mg.; pyridoxine hydrochloride (vitamin B_6), 1 mg.; niacinamide (5 MDR), 50 mg.; choline†, 100 mg.; inositol†, 100 mg.; calcium glycerophosphate, 100 mg. (supplies 2% MDR for calcium and for phosphorus) and 1 mg. each of the following: cobalt (as chloride), manganese (as sulfate), magnesium (as acetate), zinc (as acetate), and molybdenum (as ammonium molybdate).

*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.



the need for a tonic knows no age

Life *can* begin at forty—except when functional fatigue causes her to feel tired all the time; to start losing interest in friends and surroundings; to look and act older than her years. Alertonic—*a prescription tonic*—can help your patient become her normal self again. Alertonic helps relieve mild depression, revive interest and restore purposeful activity promptly...with a formula that is efficient *and* economical. Alertonic contains a mild central stimulant (pipradrol hydrochloride), 15% alcohol, essential vitamins and minerals. No hormones or MAO-inhibiting drugs are included. No iron. No iodine. One pleasant-tasting tablespoonful before each meal comprises the usual daily dose.

Indications: 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

Contraindications: As with other drugs with CNS-stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive-compulsive states.

Side Effects: Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

Dosage: Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

THE WM. S. MERRELL COMPANY
Division of Richardson-Merrell Inc.
Cincinnati, Ohio/Weston, Ontario

Merrell

CICERO'S PROGNOSIS

(Continued from Page 901)

But perhaps all this is in keeping with natural law. The children of Hamlin followed the Pied Piper to ruin, the people of Germany and Italy followed Hitler and Mussolini, the lemmings of Norway rush to the sea to drown and the grunnions of the West Coast rush from the sea to flop on the beach and die. The Roman republic was destroyed when the urban leaders pampered its populace with free handouts and a promise of a better day Perhaps Benjamin Franklin knew what he was talking about when he told the young nation, after it had adopted its Constitution, in substance, that they had gained a free and independent nation, but did not have the common sense to keep it.

Reprinted from Worcester Medical News, Inc.

PARKWOOD HOSPITAL LONG-TERM PSYCHIATRIC FACILITY

Parkwood Hospital, a new forty-bed, long-term psychiatric treatment center, has been established in Atlanta.

More than thirty psychiatrists can treat patients at Parkwood. Dr. August S. Yochem, Jr. is the acting Medical Director. A trained staff of psychiatric nurses and aides create a favorable milieu for the handling of disturbed patients. In addition, our staff includes a registered occupational therapist who has a large, well equipped occupational therapy department, and a registered music therapist —both of whom assist in carrying out doctors' orders for diversified disciplines. Additional facilities include X-ray, laboratory, pharmacy, minor surgery, patient beauty parlor and outside recreational area.

Alcoholic and narcotic addiction cases in their acute stages will not be admitted. After the acute phase has passed, if the patient will accept long-term psychiatric treatment, his admission is possible.

Sparkling Soft Drinks . . .

pleasure for patients who need liquids



Soft drinks are welcomed by patients on a liquid diet and by those who need additional fluids to maintain bodily functions. Since the amount of liquids is so important, flavorful soft drinks are often recommended. Carbonated beverages are useful for replenishing liquids when fever is present or when other foods and beverages cannot be tolerated. There's a psychological advantage, too—patient is happy to follow doctor's orders when they are so pleasant and enjoyable. Write for "Sparkling Soft Drinks" and "Liquids for Living."

Alabama Bottlers Association

P. O. Box 2181

Montgomery, Alabama 36103

The Woman's Auxiliary

Don't Just Join, BELONG

My appreciation to the Woman's Auxiliary of the Medical Association of the State of Alabama for bestowing on me the honor of being president, and I undertake the responsibility with humbleness, intending to work. I ask each member's support, reminding you; "LIGHT IS THE TASK WHEN MANY SHARE THE TOIL." (Homer)

We now have an approximate membership of 1,350 members located in 35 counties. Three new counties affiliated this past year. Physicians, encourage your wife to join and help with a coordinated effort to support your profession. Our organization is to aid you, and a better public image is presented when doctors' wives involve themselves in as many worthwhile projects as they can successfully handle.

Now is the time to sharpen your awareness of what can and what needs to be done. Doctors' wives make your first allegiance to your husband, and the profession he represents, by becoming more informed on the objectives of the Auxiliary. Recognize the numerous problems of your husband's profession, in order to help with a solution. You must feel a loyalty and show sincerity and enthusiasm for your endeavor to be effective. Budget your hours so that they become profitable to your family, your husband's profession, and your community.

Learn and understand Auxiliary aims. As a large group we do not share entirely common interests, one member's interest may be another's "cup of tea," but we can often take our "pet Projects," put them together and progress evolves. In the health field we have numerous committees with diversified interests. Find your interest, and join with other diligent working members.

The large scale national abuse of our husband's profession should bring each of us to an awakening realization that we are needed, and we need friends from all walks of life. Abraham Lincoln said, "The struggle of today is not altogether for today; it is for the vast future also. With a reliance on Providence—all the more firm and earnest—let us proceed in the great task which events have devolved upon us."

Mrs. Ira B. Patton,
President

Arteriosclerosis Council Schedules Annual Meeting

The annual meeting of the American Heart Association's Council on Arteriosclerosis will be held on Wednesday and Thursday, October 19-20, in New York City, immediately preceding the Association's Annual Scientific Sessions.

Abstracts of papers to be presented at the separate two-day Council meeting must be received before May 15. Official application forms for submitting abstracts, not to exceed 250 words, may be obtained from Alfred M. Bennett, M. D., American Heart Association, 44 East 23rd Street, New York, N. Y. 10010.

A Key Site of Action of the Protoveratrine A in Salutensin

"The main function of the carotid sinus is regulation of the blood pressure...."[1]

The veratrum component of Salutensin acts here (and in the myocardium), initiating "...a reflex fall in blood pressure through a generalized vasodilation and fall in heart rate."[2]



SCHWENK

This is a logical Blood Pressure Regulator

BECAUSE IT ENHANCES THE BODY'S OWN MECHANISMS FOR REDUCING BLOOD PRESSURE

In mild to moderate hypertension:

Salutensin enhances the body's own mechanisms for lowering blood pressure. The veratrum component of Salutensin acts on the carotid sinus and myocardial receptors, initiating "...a reflex fall in blood pressure through a generalized vasodilation and fall in heart rate."[2] To achieve this reflex modification of hypertension, Salutensin utilizes protoveratrine A. In addition, to facilitate and maintain blood pressure reduction, Salutensin incorporates reserpine and a highly effective thiazide. In general, side effects have been reported infrequently but may include those listed in the therapeutic summary.

Simple dosage—low-cost therapy: Many patients on Salutensin respond to 1 tablet *b.i.d.* Long-term economy is assured, since dosage can frequently be lowered after initial control is established.

Available: Prescription-size bottles of 60 tablets.

References: 1. Editorial: JAMA *191*:592 (Feb. 15) 1965. 2. Meilman, E., in Moyer, J.H.: Hypertension, Philadelphia, W.B. Saunders Company, 1959, p. 395.

BRISTOL THERAPEUTIC SUMMARY
For complete information consult Official Package Circular.
Indications: Essential hypertension.
Warnings: Small-bowel lesions (obstruction, hemorrhage, perforation) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs.
Contraindications: Salutensin is contraindicated in severe depression.
Precautions: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss, which may cause digitalis intoxication, responds to potassium-rich foods, potassium chloride or, if necessary, stopping therapy. Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy two weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution with patients with peptic ulcers or renal insufficiency (if severe, Salutensin is contraindicated).
Side Effects: Hydroflumethiazide: Purpura plus or minus thrombocytopenia, hyperuricemia, leukopenia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. *Reserpine:* Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth and, with overdosage, agitation, insomnia and nightmares. *Protoveratrine A:* Nausea, vomiting, cardiac arrhythmia, prostration, excessive hypotension and bradycardia. (Treat bradycardia with atropine and hypotension with vasopressors.)
Usual Dose: 1 tablet *b.i.d.*

BRISTOL
BRISTOL LABORATORIES
Division of Bristol-Myers Co.
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SCIENTISTS GATHER FOR NUTRITION SYMPOSIUM

Ten distinguished scientists from the United States, Puerto Rico and England gathered at the University of Alabama Medical Center in Birmingham on March 24th to present a Symposium honoring Dr. Tom D. Spies.

In addition to paying homage to the many accomplishments of Dr. Spies in the field of clinical nutrition, the speakers presented scientific paper on a wide variety of timely and important topics. Subjects ranged from the effects of poverty on nutrition in the South 30 years ago and today, to current concepts of vitamin metabolism in cells, and possible toxic effects of certain foods.

Participants included: Dr. William H. Crosby, Professor of Medicine, Tufts New England Medical Center, Boston; Dr. William J. Darby, Professor of Nutrition, Vanderbilt University School of Medicine, Nashville; Professor Alastair Frazer, Department of Medical Biochemistry and Pharmacology, The University of Birmingham, Birmingham, England; Dr. Grace Goldsmith, Professor of Medicine, Tulane University School of Medicine, New Orleans; Dr. Leonard T. Kurland, Section of Biometry and Medical Statistics, The Mayo Clinic, Rochester; Dr. Robert E. Olson, Professor and Chairman, Department of Biochemistry, Saint Louis University School of Medicine, St. Louis; Dr. Robert E. Stone, Tom D. Spies Professor of Nutrition, Northwestern University, Chicago; Dr. Ramon Suarez, Director, Mimiya Hospital, San Juan, Puerto Rico; Dr. Richard W. Vilter, Professor and Director, Department of Internal Medicine, University of Cincinnati College of Medicine, Cincinnati; Dr. Charles E. Butterworth, Jr., Director, Division of Nutrition of the Department of Medicine, Medical College, Birmingham; Dr. Walter B. Frommeyer, Jr., Professor and Chairman Department of Medicine, and Director, Division of Medical Education, Department of Medicine, Medical College of Alabama, Birmingham; Dr. S. Richardson Hill, Jr., Professor of Medicine and Dean, Medical College of Alabama, Birmingham. Of these Drs. Suarez, Vilter, Stone, and Frommeyer were associated with Dr. Spies and collaborated with him on a number of research projects.

Dr. Suarez, who assisted Dr. Spies in the pioneer use of folic acid in Puerto Rico in 1945, reported that the first patient to receive this vitamin is still being maintained in good health by its use 21 years later.

The meeting was arranged by Dr. C. E. Butterworth, Jr., Director of the Medical College of Alabama's Nutrition Division in the Department of Medicine. It was sponsored jointly by the National Dairy Council, the AMA Council on Foods and Nutrition, and by the Medical Center.

The same groups sponsored an all day workshop session the following day devoted to problems of medical education and the organization of nutrition units in modern medical centers.

In addition to the speakers listed above, the workshop was attended by the following educators and nutritionists: Dr. George Hamwi, Professor of Medicine, Ohio State University; Dr. Parker Vanamee, Memorial Sloan-Kettering Center, New York; Dr. Merrill Read, Director of Research and Education, National Dairy Council, Chicago; Drs. Philip White and Ogden Johnson of the AMA Council on Foods and Nutrition, Chicago; Dr. John McKibbin, Professor Biochemistry, Medical College of Alabama; and Dr. Neige Todhunter, Dean of the School of Home Economics, University of Alabama.

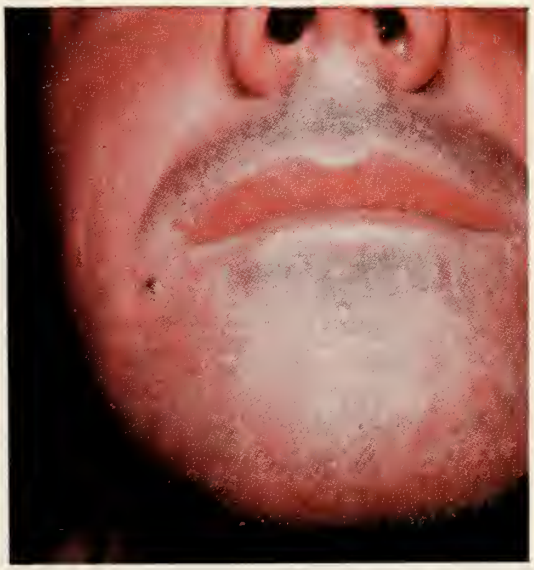
The series of meetings was brought to a close by a meeting of the AMA Council at the Parliament House on Saturday, March 28th.

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RESEARCH BASIS OF COMMUNITY HEALTH SERVICES

Recent Federal health legislation and the need for massive solutions to the urban explosion will require the United States to look upon community health services as a primary social resource which affects the quality of many aspects of national life.

The "health services industry" is already an economic giant. In the year that ended June 30, 1964, a total of 35.4 billion dollars were spent for health and medical care, or 5.9 per cent of U. S. gross national product. The health services industry is also the third largest employer.

Health services may be seen as a sector of the social system whose future growth requires the guidance of theories, principles, policies and information produced by research. Such research could create methods varied and powerful enough to improve the quality of medical care, use available resources efficiently, and integrate the patterns of health institutions and services with the inevitable expansion of dense urban populations.

These are among the conclusions of a two-day discussion of research in community health services and medical care by university researchers and educators in the medical and social sciences, hospital and health department administrators, and several government and private foundation officials held at the University of Chicago. Representatives came from many parts of the United States and from Great Britain, Belgium, and Canada. The meeting was one of a series of activities undertaken by the Health Services Research Study Section of the U. S. Public Health Service to develop effective multidisciplinary research in health services at the community level.

Among the participants was Mr. Matthew F. McNulty, Jr., General Director, University of Alabama Hospitals and Clinics, Birmingham.

Major subjects covered were:

- The problems of conducting research on issues of social policy;
- The connection between economic development and the contribution of health services to the quality of community life;
- Problems in evaluating the effectiveness and efficiency of medical care;
- The measurement of demand for and use of health services;
- The design of hospitals and other health facilities;
- Regional and urban planning and organization of agencies and services.

The remaining ten papers, slated for review in May 1966, will cover the following areas:

- The concept of need for health services;
- The concept of indigence in relation to health services;
- The contribution of health services to the economy at large;
- Research in qualitative and quantitative aspects of manpower for health services;
- Research into the organization of medical practice;
- Research problems in the evaluation of service demonstrations;
- Problems in coordinated areawide planning for personal health services;
- Studies of the process of information in relation to provision of health services;
- Political ingredients of health services;
- Organizational theory in relation to health services.

Regarding research on social policy mat-

ters, it was suggested that historically in the United States social policies in the health field have been based on a general popular consensus, rather than theoretical concepts developed from research findings. However, research has helped to implement the consensus and assist policy-making.

A major difficulty in evaluating the quality of medical care has been in securing a stable definition of "medical care." The principal paper on this subject suggested focussing attention on the process by which doctors, nurses and other health workers actually provide personal care to individuals. Manageable segments of the total process then can be selected for intensive study. This might permit establishing a series of intermediate end points within the total patient care process.

Understanding the use of health services, and measuring the demand for health services were shown to be closely interdependent. The tools of economic analysis cannot fully explain demand unless cultural and demographic characteristics which influence behavior in the face of a health threat are known. Also, for a full analysis of demand it is necessary that considerable progress be made in analysis of the components and combinations of medical technique available to the doctor in selecting appropriate treatments. Thus, these areas are related to the state of research progress in the evaluation of medical care, using some such method as that suggested in the paper on intermediate end points in the care process.

CONSTANT SNEEZING because of an allergy such as hay fever may lead to a malfunction of jaw and facial muscles, Dr. Robert J. Nelsen, Rockville, Md., has reported.—*Amer. Dental Assn. Clipsheet*, 2, 1965.

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Clinical Evaluation of a New Preparation Combining Penicillin with Triple Sulfonamide

Thomas C. Nolan, M. D. and

William A. Daniel, Jr., M. D.

Montgomery, Alabama

A considerable amount of interest has developed during recent years in the use of combinations of antibiotics and sulfonamides for the treatment of infectious diseases. One of the primary aims of such combined treatment is to provide increased antibacterial potency.[1] In addition, such combined therapy may provide a broader spectrum of antibacterial activity and it may prevent the development of bacterial resistance to the administered therapy.[1, 2, 3] Also, such therapy may be used in mixed infections.[3] Finally, since smaller doses of each agent may be needed than would ordinarily be required of each alone, combined therapy may reduce the risk of reactions or toxic effects.[2]

Group A beta hemolytic streptococci are common pathogens in the production of bacterial infections of the upper respiratory tract in children.[4, 5, 6] Their eradication from the tissues is important in order to prevent the occurrence of complications, particularly the development of rheumatic fever.[4] Penicillin has an antibacterial action against most pathogenic cocci that do not produce penicillinase[7] and in very small concentrations rapidly kills group A beta hemolytic streptococci.[5] Sulfonamides have a wide range of antimicrobial activity against both gram-positive and gram-negative organisms, but in general they have only a bacteriostatic effect in the body.[1] Use of sulfonamides in the treatment of acute hemolytic streptococcal infections may attenuate the disease, but it does not consistently eradicate the causative organisms.[1] Since combinations of penicillin with sulfonamide mixtures have been found to have greater antibacterial activity, both **in vitro** and **in vivo** upon beta hemolytic streptococci than have either penicillin or the sulfonamides alone,[8, 9] combined treatment with these agents would be expected to provide rapid and effective control of beta hemolytic streptococcal infections.

The present report concerns the use of a new high dosage penicillin-sulfonamide preparation in the treatment of children with infections of the upper respiratory tract and

ear. That this preparation proved to be effective in combating such infections, especially those caused by beta hemolytic streptococci, is evident from the following brief report.

MATERIALS AND METHODS

The subjects of this study were 28 children with infections of the upper respiratory tract and ear, who were seen during routine office visits. Of these patients, ten were males and 18 females. Their ages were as follows:

Age	No. Patients
Less than 2 years	1
2-3	6
4-5	4
6-7	7
8-9	5
10-12	5

When first seen, all patients had temperatures of more than 102°F., and all showed marked redness of the pharynx or tonsils and/or symptoms of otitis media. Clinically, all these children were considered sufficiently ill to require treatment.

Each of the 28 children was treated with the preparation designated as Pentid® "400"—Sulfas for Syrup*, which is a combined formulation of buffered penicillin powder with sulfadiazine, sulfamethazine and sulfamerazine. When prepared with water, each teaspoonful (5 cc.) provides 250 mg. (400,000 units) potassium penicillin G and 500 mg. trisulfapyrimidines (167 mg. each of sulfadiazine, sulfamethazine, and sulfamerazine). This mixture was administered in doses of one teaspoonful four times a day to 25 of the 28 patients. Two patients, aged 22 months and two years, respectively, received three-fourths of a teaspoonful four times a day, and another patient received one teaspoonful three times a day.

*Pentid® is a tradename of E. R. Squibb & Sons. The combined penicillin-sulfonamide preparation used in these tests was generously supplied by John E. Beck, M. D. of The Squibb Institute for Medical Research, New Brunswick, N. J.

Throat cultures were obtained from all patients before treatment and were streaked on blood agar plates containing sheep red blood cells. These cultures were also examined by the fluorescent antibody method for beta hemolytic streptococci, Group A, which has been described elsewhere.[10] All children were re-examined after four days of treatment. At that time an additional culture was obtained and tests were repeated to detect the presence of beta hemolytic streptococci. If fever was present on the second visit or if the culture was positive for beta hemolytic streptococci, another four days of medication was prescribed. Treatment was continued with the antibiotic preparation for four days in 12 of the 28 children. Four other children were kept on the drug for five days, one was treated for six days, another was treated for seven days, and four additional patients were continued on treatment for nine days. The remaining six patients were continued on the antibiotic preparation for ten days.

RESULTS

Table I shows the diagnosis, the duration of treatment with the penicillin-sulfonamide syrup, and the clinical responses in the 28 children. Twenty children showed excellent responses and seven additional children showed good responses. The remaining patient showed only a fair response to treatment with the antibiotic syrup. Whereas cultures obtained before treatment were positive for beta hemolytic streptococci in 15 patients, repeat cultures after four days of treatment revealed that only one of these patients still harbored this organism. A third culture taken from this one patient after four additional days of therapy, however, proved to be negative. All of these patients recovered after four to ten days of treatment with the antibiotic-sulfonamide syrup. Initial cultures were negative for beta hemolytic streptococcus in the remaining 13 patients, but all of these patients recovered after treatment for from four to seven days. No side effects were

Table I Results in 28 Patients Treated With A Combined Preparation of Buffered Penicillin Powder, Sulfadiazine, Sulfamethazine and Sulfamerazine*

Diagnosis	No. of Patients	Duration of Treatment (Days)	Clinical Response (No. of Patients) Excellent	Good	Fair	Poor
Streptococcal Throat Infection	13	4-10	11	2		
Otitis Media and Streptococcal Throat Infection	2	4-9	2			
Tonsillitis	7	4-6	4	3		
Otitis Media and Pharyngitis	4	4-7	2	2		
Pharyngitis	2	4-5	1		1	
Total	28	4-10	20	7	1	

*Administered in doses of 1 teaspoonful, four times daily to 25 patients; of 1 teaspoonful three times daily to 1 patient; of 3/4 teaspoonful four times daily to 2 patients.

observed and no evidence of toxicity was seen in any of the patients treated with the penicillin-sulfonamide mixture.

DISCUSSION

It is difficult to evaluate the effectiveness of any medication administered to patients with bacterial infections of the upper respiratory tract and/or ear without the finding of positive culture before treatment becoming negative with treatment. In 15 patients of this series initial cultures were positive for Group A beta hemolytic streptococcus and in all of these patients cultures became negative during treatment. We believe that recovery in these 15 patients with proved beta hemolytic streptococcal infections can be attributed to the administered medication.

Initial cultures from the 13 remaining patients of the series were negative for beta hemolytic streptococcus. The presenting signs and symptoms and the clinical responses to treatment in seven of these 13 patients, however, indicated that recovery in their cases may have been aided by the administered medication. Of the six other patients whose pretreatment cultures did not show beta hemolytic streptococci, all recovered after four to seven days of therapy, but the effectiveness of the drug could not be evaluated in their cases. Infection with viruses may have been the cause of illness in this group.

SUMMARY

A total of 28 children with severe infections of the upper respiratory tract and/or ear was treated with a new penicillin-sulfonamide preparation, which combines in each 5 cc. 400,000 units of potassium penicillin G and 167 mg. each of sulfadiazine, sulfamethazine and sulfamerazine, with sodium phosphates as buffers. The usual dose was one teaspoonful four times a day, although one patient received one teaspoonful three times a day and two other patients, aged 22 months and two years respectively received daily doses of three-fourths teaspoonful four times a day. Treatment was continued for periods of from four to ten days in the 28 patients. Results were **excellent** in 20 patients, **good** in seven, and **fair** in one. Recovery could be directly attributed to the medication in 15 patients

who had proved beta hemolytic streptococcal infections and whose cultures became negative following treatment. For the remaining 13 patients with pretreatment cultures that were negative for beta hemolytic streptococcus, the recovery of seven may have been aided by the medication, but the effectiveness of the medication in six other patients could not be evaluated.

REFERENCES

1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics. 2nd Ed. The Macmillan Co., 1955, New York. pp. 1279-1334.

2. Kolmer, J. A.: The synergistic or additive activity of chemotherapeutic compounds. Am. J. Med. Sci. 215: 135, 1948.

3. Price, C. W., *et al.*: Studies of the combined action of antibiotics and sulfonamides. Am. J. Public Health 39: 340, 1949.

4. Cecil, R. L. and Loeb, R. F.: A Textbook of Medicine. 10th Ed., W. B. Saunders Co. 1959, Philadelphia. pp. 136-139.

5. High, R. H. and Huang, N. N.: Penicillin G and related compounds. Pediat. Clin. N. Am. 10 (3): 745, 1963.

6. Miller, J. M., Stancer, S. L. and Massell, B. F.: A controlled study of beta hemolytic streptococcal infection in rheumatic families. Am. J. Med. 25: 825, 1958.

7. Welch, H.: A Guide to Antibiotic Therapy. New York Medical Encyclopedia, Inc. 1959.

8. Shlaes, W. H., *et al.*: The antibacterial action of combinations of penicillin and sulfonamides. Antibiotic Chemotherapy 2: 2124, 1952.

9. Miller. A. K. and Verwey, W. F.: Effect of Probenecid on combined penicillin and triple sulfonamides therapy of experimental streptococcal infections. Antibiotic chemotherapy 4: 169, 1954.

10. Cherry, W. B., *et al.*: Fluorescent Antibody techniques in diagnosis of communicable diseases, U. S. Department of Health, Education and Welfare, Public Health Service, Bureau of State Services, Communicable Disease Center, Atlanta, 1960.

NEW TEST FOR MONONUCLEOSIS

A new test for mononucleosis has been developed. Its speed—the test can be done in 2 minutes or less as against 1½ to 5 hours for one previously used—and its accuracy are factors which endow the test with significant values. Mononucleosis symptoms—fever, sore throat, and lymph node enlargement—resemble those of other, more serious diseases, such as acute leukemia, hepatitis, and forms of meningitis and encephalitis. Since meningitis requires prompt and specific treatment different from that used against mononucleosis, the wrong diagnosis could have serious consequences. ("New test for mononucleosis," *The Illinois Medical Journal,* December 1965).

HERPES SIMPLEX A PROBLEM FOR WRESTLERS

Efforts are being made to control spread of herpes simplex, a skin infection which hit wrestlers hard last winter, especially among college wrestling teams in the northeastern United States. Herpes simplex, commonly recognized as the nuisance cold sore on the lip, usually isn't dangerous. For wrestlers, the infection is more than a nuisance. The skin lesions can spread rapidly from wrestler to wrestler. Sometimes painful, they may be accompanied by fever, chills, headache, and general malaise for two or three weeks. Lesions may appear on the eye, in some cases with residual effects. Wrestlers are particularly vulnerable to herpes simplex because of the sweaty contact and frequent skin abrasions common to the sport. Apparently wrestling mats and wearing apparel aren't transmitters of this infection. The virus is passed directly from person to person. Coaches and athletes are asked to be alert for signs of herpes infection. When there is diagnosis of infection, the athlete should be excluded from participation until his skin is clear. (Statement on herpes simplex infection among wrestlers by the AMA Committee on the Medical Aspects of Sports, October 1965).

Upper Extremity Anesthesia By A Simple Block Technique

James H. Price, M. D. and

Chester W. White, Jr., M. D.

Birmingham, Alabama

Regional anesthesia is frequently preferable for procedures on the upper extremity, especially under office or emergency circumstances. Suitable results may be expected with a number of techniques, but the axillary approach to the brachial plexus block has several advantages which are not generally appreciated. This block is relatively simple, successful in approximately 85 per cent of attempts, and may be performed safely without unusual precautions. We believe that this block has a place in the practice of many physicians and that patient care can be improved by its wider utilization. Anesthesia of the upper extremity can also be obtained by blocking the brachial plexus using the supraclavicular approach; this technique is more difficult and is occasionally accompanied by complications such as pneumothorax. Safe and dependable use of the supraclavicular approach is only possible after considerable experience. By contrast, the axillary approach is usually mastered rapidly and can be successfully employed by those who administer regional anesthesia infrequently.

Block of the brachial plexus was first described by Halsted in 1884. The plexus was exposed surgically and the injection of cocaine was made under direct vision. In 1911, the trunks of the brachial plexus were injected blindly through the axilla by Hirschel. This block was difficult to master and Kulenkanpff reported on the supraclavicular technique in 1912. In 1921, Reding blocked the terminal nerves in the axilla and while the results were good, the block was overlooked until 1949 when it was reintroduced by Accardo and Adriani. Burnham visualized the vascular sheath and devised the perivascular technique in 1958.

Any operative procedure involving the upper extremity can be managed with conduction techniques, but the axillary block does not produce adequate pain relief above the distal one-third of the upper arm. Many surgical procedures of the upper extremity, such as fracture, amputation, or lacerations, are secondary to trauma. These necessitate surgery on an emergency basis, complicated by the special hazard of a full stomach. A patient who is experiencing pain may have little or no gastric emptying for 12 to 18 hours following injury. The danger of vomiting and aspiration substantially contraindicates general anesthesia in many such situations. Regional block is also useful for elective operative procedures on the upper extremity; indeed, it is indicated in acute and chronic respiratory tract disease, metabolic upset, and often in patients who are poor anesthetic risks because of age, debility, or dehydration. It may also be chosen for the patient who prefers to remain awake, because general anesthesia is not available, and for office or

Dr. James H. Price is currently assistant professor of Anesthesia at the University of Alabama College of Medicine. He graduated from the University of Tennessee College of Medicine in 1954. After seven years of general practice in Chatom, Alabama, he returned to the University of Tennessee and completed his anesthesia residency.

Dr. Chester W. White, Jr. is the Professor and Chairman of the Department of Anesthesia at the Medical College of Alabama and is Anesthesiologist-in-Chief at the University of Alabama Hospitals and Clinics in Birmingham, Alabama.

outpatient surgery. The use of regional anesthesia simplifies postoperative care because the patient is awake and can do many things for himself.

Regional anesthesia does not replace general anesthesia. A few people have an idiosyncrasy to many or all local anesthetic agents. Axillary block, and in fact all conduction methods are probably best avoided in the very young patient, who is likely to be unco-operative. The hysterical patient and the malingerer are treated as children, for they seldom tolerate regional anesthesia well. A nerve block should not be done in an area of infection or in the presence of septicemia because of the danger of neuritis or abscess formation. Diagnosed or suspected nervous system disease is a relative contra-indication because later manifestations of the neurological problem may be erroneously attributed to the anesthetic technique. The layman's fears of spinal anesthesia are based in part on the neurological effects of central nervous system syphilis which followed, but was not related to, diagnostic lumbar puncture.

The outstanding advantage of the axillary block is the ease with which this method may be mastered by the occasional user. The landmarks are readily identified in all but the very obese patient, which helps to explain why most attempted blocks are clinically satisfactory. Axillary block is as safe as is the use of an equal amount of the block agent in local infiltration, for the "-caine" reaction is the only real danger of the technique. Local anesthetic agents are relatively inexpensive, and the necessary equipment consists only of needles and syringes. Performing the block is simple and it is adaptable to circumstances outside of the office or hospital; one should remember, however, that reactions are possible and should be prepared with resuscitative equipment and drugs. Good muscle relaxation is readily obtained. Pneumothorax, a fairly frequent complication of the supraclavicular approach, is virtually impossible with this technique.

One must be alert for the rare complications. The most likely is the introduction of the needle into the artery or vein. If anesthetic agent is injected intravenously, the high blood level may lead to toxic reaction. A hematoma may result from arterial puncture, but this is rare when a small needle (22 gauge or smaller) is used. Infection is a possibility anytime a needle is inserted into the skin, however the axilla is quite vascular and infections are rare. In an experimental series of 100 axillary blocks, in which a resident in training made no attempt at asepsis, except for the use of sterile equipment and drugs, no infections occurred at the block site. This does not imply that asepsis may be ignored, but it is apparent that reasonable care is all that is required. Neuritis and peripheral nerve injury are potential complications, but these have not been seen in a series of more than 500 cases. A minor disadvantage of the axillary block is the lack of anesthesia to the upper arm and shoulder and the possibility of tourniquet discomfort.

Any of the injectable local anesthetic agents may be used for this block. Lidocaine (Xylocaine®) or mepivacaine (Carbocaine®) are popular agents which will give anesthesia for a duration of ninety minutes or longer. When more prolonged effect is desired, 10 milligrams of tetracaine (Pontocaine®) may be added to the basic agent to produce a block which may be expected to last for approximately four hours. The typical healthy adult patient, weighing about 70 kilograms, will normally tolerate a dose of 500 milligrams of mepivacaine or lidocaine without toxic manifestations, but the dosage must be adjusted in relation to the size and physical status of the patient. Epinephrine (1:200,000-1:100,000 in the solution of anesthetic agent) will also extend the block by slowing absorption of the drug. The vasoconstriction caused by the epinephrine delays absorption and prolongs action as much as 50 per cent; the likelihood of systemic reaction is also diminished materially.

Toxic reactions to local anesthetics result from high blood levels of the agent. Overdosage may result from the use of excessive quantities of the drug (whether given by in-

jection or topically) or from inadvertent intravascular injection. A very small percentage of patients are excessively affected by local anesthetics and respond to small amounts as though they had been overdosed. True allergies and sensitivity reactions are rarely observed, but they are occasionally manifested in the form of anaphylaxis, dermatitis, urticaria, or bronchospasm. Excess total dose is a more frequent cause of reactions. Toxic manifestations involve primarily the central nervous system, the cardiovascular system, and the respiratory system. The central nervous system is first stimulated as evidenced by nervousness, disorientation, confusion, and—in extreme cases—convulsions; depression follows. The cardiovascular system is depressed by a direct action of the anesthetic agent on the myocardium and the peripheral vessels. Respiration is depressed by the direct effect of the anesthetic agent on the respiratory centers.

An allergic or anaphylactic reaction occurs immediately after the agent is administered, whereas an overdose reaction usually occurs ten to 15 minutes after the administration of the drug. The time interval for systemic toxicity is shortened materially after direct intravascular injection. With anaphylactic reactions, there is sudden collapse of both the respiratory and the cardiovascular functions. This complication occurs rarely and is treated empirically by placing the patient in a shock position, administering oxygen, and supporting the circulation with intravenous fluids, cortisone and vasopressors. Epinephrine in small repeated doses is very effective therapy. The means for instituting these therapeutic measures should be immediately at hand whenever local anesthetics are used. An alteration in mental attitude is often the first change noted when toxicity develops. Initial euphoria is frequent; the patient may repeat a word or phrase several times. Some become apprehensive and have a feeling of impending disaster; a few will become drowsy and later comatose. As the reaction progresses a shock-like state characterized by pallor, perspiration, and syncope associated with bradycardia and hypotension may result. Respiration may become irregular and mechanical obstruction of the airway will often occur. Muscular twitching and purposeless movements progressing to convulsions are manifestations of central nervous system irritation. If convulsions occur, effective respiration ceases; hypoxia must be treated by assisting ventilation and vascular depression by vasomotor drugs to prevent collapse and death.

Toxic reactions are minimized or avoided by use of simple precautions. (1) Total dose of the drug should be limited to the amount which is reasonably expected to give an adequate block. (2) The rate of absorption of a given dose of local anesthetic agent is slowest from a dilute solution, so that concentration should be as low as compatible with the size of the nerve to be blocked. Lidocaine is effective in a 0.25 per cent to 0.5 per cent solution for local infiltration, whereas a 2 per cent solution will be required to block a large nerve such as the sciatic or the femoral. (3) Intravenous injection can be avoided when injecting a local agent by aspirating before the injection. The amount injected intravenously will be very small if the agent is injected while moving the needle. (4) The addition of adrenalin, or any vasoconstrictor, to the anesthetic solution slows systemic absorption. The vasoconstrictor, however, can cause apprehension, palpitations, tachycardia, and elevations of the blood pressure which must be distinguished from a systemic toxic reaction. Absorption is quite rapid in highly vascular areas, making a reaction more likely if vasoconstrictors are not used. (5) If a patient gives a history of previous local anesthetic reactions, caution dictates the use of an agent of a different chemical nature. Verbal and visual contact with the patient should be maintained to detect early changes which suggest toxic or sensitivity manifestations. If a toxic reaction does occur, the treatment is dependent on the severity of the symptoms. If slight mental changes are all that occur, this can be adequately treated by placing the patient in a supine position and simple moni-

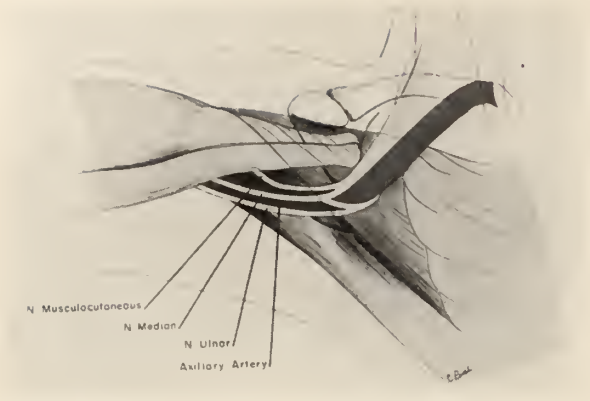


Figure One.

Illustrates the close association of the terminal nerves of the brachial plexus as they are grouped about the axillary artery in the proximal axilla. The radial nerve is immediately posterior to the artery.

toring. If there is hypotension or hypoventilation, oxygen is administered and intravenous fluids are started. If a drop in blood pressure becomes notable, or if signs of shock appear, vasopressors should be given intravenously in intermittent small doses or as a dilute infusion. If convulsions occur, these can be controlled by the use of intravenous thiobarbiturates or short acting muscle relaxants. If large doses of barbiturates are used to treat convulsions they cause later respiratory depression so that prolonged respiratory assistance may be required. Severe hypoxia is the important effect of convulsions; this should be avoided by ventilation with oxygen and by control of the convulsions so that effective oxygenation can be achieved.

TECHNIQUE FOR PERFORMING AXILLARY BRACHIAL BLOCK

The patient is placed in the supine position with the head turned away from the side to be blocked. The arm which is to be blocked is abducted and externally rotated so that the hand rests beside the head in the region of the occiput. The physician may stand above the shoulder, but better visualization of the anatomy is possible if he stands facing the axilla. The position of the brachial artery is palpated as high in the axilla as possible. The axilla is prepped by shaving, washing with soap or pHisoderm and water, and application of an antiseptic tincture of choice. Sterile technique minimizes the probability of neuritis secondary to infection. High in the axilla, the terminal branches of the brachial plexus are grouped about the axillary artery in a fascial sheath (figure one). The musculocutaneous nerve comes out of the fascial sheath just distal to the pectoralis minor muscle which allows this nerve to be missed if the block is executed distal to the insertion of this muscle. The relationship of the nerve, artery, veins and the fascial sheath are demonstrated in figure two.

After the axillary artery is identified in the proximal axilla, a short twenty-four gauge or twenty-five gauge needle is placed suc-

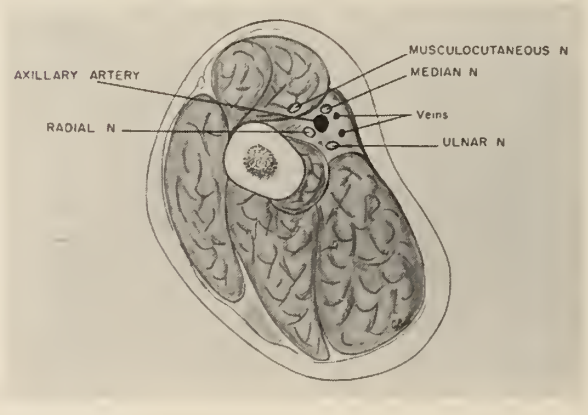


Figure Two.

A cross section through the upper arm distal to the insertion of the pectoralis major muscle. The fascial compartment surrounds the axillary artery and the nerves. The musculocutaneous nerve leaves the fascial sheath one centimeter proximally and will be anesthetized when the injection is made at the level of the proximal axilla.

cessively anterior and posterior to it. The artery is stabilized with two fingers of one hand while the needle is controlled by the other hand. Most often a distinct pop can be felt when the fascial sheath is pierced by the needle. Visible pulsations are transmitted through the shaft of the needle when it is adjacent to the axillary artery. If this small needle inadvertently enters the artery, it can be removed, and after watching a few moments to be sure a hematoma will not occur, can be replaced adjacent to the artery. If a vein is entered, venous pressure is sufficient to cause blood to flow out of the needle rather than allowing air to enter. If bleeding occurs, the needle should be replaced at a slightly different location. The needles are best inserted without an attached syringe to allow better tactile sensation. It is not necessary to elicit paresthesias; but if they are obtained, the anesthetic solution is injected at that point. An average size adult will usually require 10 cc. of anesthetic solution on either side of the artery. If complete muscle relaxation is desired, 2 per cent anesthetic solution is used, whereas if sensory block only is desired, 1 per cent or 1.5 per cent may be used. 20 cc. of 2 per cent lidocaine is within the usual safe dose limit. It frequently requires as long as twenty minutes for the block to become completely effective. The speed of onset of block is accelerated if paresthesias are sought and the drug injected at that point. It often requires as long to elicit individual paresthesias as to wait for the diffusion of the agent within the vascular sheath; there is no definite advantage to be expected from the more difficult procedure. Within five minutes of injection of the block agent, venous distention is usually evident indicating sympathetic blockade. Block of the larger nerve fibers is usually apparent within fifteen minutes as indicated by loss of temperature sensation, pin prick sensation, and finally motor function. Triceps function is lost early so that the patient is unable to extend the forearm. If a hemostatic tourniquet is to be used, it will occasionally be necessary to inject an annular subcutaneous wheal of 0.25 per cent anesthetic solution about the upper arm above the tourniquet. Some patients will begin to have discomfort from the tourniquet long before the block wears off. As stated above, even an effective block should not be expected to give good anesthesia proximal to the middle third of the upper arm.

Axillary block of the brachial plexus can be safely and easily accomplished. This type of upper extremity anesthesia can find wide application in the everyday practice of medicine and will benefit both the physician and the patient. The physician will find it a reliable and safe method of anesthetizing the upper extremity while the patient is spared a general anesthetic. The technique of performing the block is simple to master and the risks are minimal. The precautions are primarily those for prevention of a local anesthetic reaction. The prevention and treatment of these reactions is discussed. This block is most useful for therapy of traumatic injuries of the upper extremity.

REFERENCES

1. Accardo, N. J., and Adriani, J.: Brachial plexus block: a simplified technic using the axillary route, South. Med. J. 42: 920, 1949.

2. Burnham, P. J.: Regional block of the great nerves of the upper arm, ANESTHESIOLOGY 19: 281, 1958.

3. Eather, K. F.: Axillary brachial plexus block (correspondence), ANESTHESIOLOGY 19: 683, 1958.

4. DeJong, R. H.: Axillary block of the brachial plexus, ANESTHESIOLOGY 22: 215, 1961.

5. Hamelberg, W., Dysart, R., and Bosomworth, P.: Perivascular axillary versus supraclavicular brachial plexus block and general anesthesia, Anes. Analg. 41: 85, 1962.

6. Moore, D. C.: Regional Block of the Upper Extremity: Supraclavicular Approach Versus Axillary Approach. Refresher course, Annual Meeting of American Society of Anesthesiologists, November 2-6, 1963.

7. Winnie, A. P., and Collins, V. J.: The Subclavian Perivascular Technique of Brachial Plexus Anesthesia, ANESTHESIOLOGY 25: 353, 1964.

Craniostenosis

Amos C. Gipson, M. D.

Partlow State School

Tuscaloosa, Alabama

Craniostenosis applies to a group of malformations of the skull in which premature closure of two or more cranial bones occurs causing intracranial pressure and results in mental retardation if operation is not performed within two to three months after birth. The coronal and sagittal sutures are the ones most commonly involved and the ones that result in severe damage to the brain if not corrected early in life.

The brain grows more during the first year of life than all the rest of a person's life. The brain grows faster than the bone during the first nine months after birth, which is the reason for the anterior fontanel to gradually increase in size up to this age. After nine months of age the growth of the brain slows down, then the bone begins to grow faster than the brain, resulting in closure of the fontanel at approximately 18 months of age.

Premature closure of the sutures produces alterations in the growth of the skull, often causing flattening of the malar bones, resulting in exophthalmus, papilledema and even optic atrophy. If papilledema occurs, it always appears during the early years of childhood when the growth of the brain is most rapid and if the child reaches the tenth year with normal vision, no fears of optic atrophy need be entertained. Some ophthalmologists describe constriction of the superior parts of the visual fields due, it is believed, to tension on the optic nerves which results from the deformity of the base of the skull. Errors of refraction are common, especially myopia. Sense of smell may also be lost or impaired. In severe cases, there is very frequently a definite intellectual deficit. The patients complain of severe and frequent headaches, and there is often some obstruction of the nasal passages due to the malformation of the nasal bones.

A few cases have come to autopsy. The brains always show evidences of compression such as flattening of the convolutions and obliteration of the sulci.

Case Report

This 13 year old patient was operated on and the sagittal suture permanently separated when two years and two months of age, which was too late to prevent an intellectual





deficit. The convolutions of the brain were found to be flattened as a result of intracranial pressure. His vision is satisfactory and he does not have optic atrophy.

Treatment

The fontanel of every newborn infant should be palpated and for several weeks thereafter, as the diagnosis can easily be made by this method alone. If craniostenosis is found, operation should be performed immediately. If this is done early enough, damage to the brain is prevented and a normal child will be the result.

References

Ford, F. R.: Diseases of the Nervous System, second edition, 1946.

FOLKLORE TESTED BY SCIENCE

The belief that the emotional attitude and behavior of the pregnant woman may affect the child she carries is as old as the human race. This belief is explored through a review of the scientific literature which deals with the possibility that the mother's negative attitude toward her pregnancy may influence her child's behavior. It is understandable that a normal woman may be anxious during pregnancy. However, a high degree of anxiety and conflicting emotions seem to have a harmful influence upon the pregnancy and have been shown to correlate with obstetric complications. In the laboratory rat, maternal stress has been shown to affect the offspring. In the human, a number of studies point in the same direction. In observations of 163 pregnant women and their offspring, the mother's negative attitude toward the pregnancy and the baby she carried was reflected in the newborn's abnormal behavior. Ways in which maternal hostility may be expressed are through excessive smoking, improper diet, obesity, alcoholism, use—or abuse—of tranquilizers, antidepressants, sleeping pills and the like. The pregnant woman's emotional conflicts may also be conveyed by means of the glandular system and the brain center which influences contractility of the uterus, oxygen supply, and development of the vascular system for transporting fluids through the body. The best hope for a normal pregnancy is in a warm and healthy relationship between the mother-to-be and her physician. (A. J. Ferreira, M. D.: "Emotional factors in prenatal environment," *The Journal of Nervous and Mental Diseases*, July 1965).

Flagyl destroys trichomonads



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No topical treatment can

Flagyl®
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metronidazole

Flagyl eliminates the difficulties and frustrations that have long attended the treatment of trichomonal infection.

These difficulties arose mainly from:

1) the failure of any previously known agent to destroy the protozoan in paravaginal crypts and glands;

2) the failure of any previously known agent to prevent reinfection by eradicating the disease in male consorts.

The introduction of Flagyl removed both of these long-standing deficiencies. Hundreds of published investigations in thousands of patients have confirmed the ability of Flagyl to cure trichomoniasis.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced a cure rate of up to 100 per cent in large series of patients.

Nothing cures trichomoniasis like Flagyl.

Dosage and Administration

In *women:* one 250-mg. oral tablet t.i.d. for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When the inserts are used one vaginal insert should be placed high in the vaginal vault each day for ten days, and concurrently two oral tablets should be taken daily.

In *men:* in whom trichomonads have been demonstrated, one 250-mg. oral tablet b.i.d. for ten days.

Contraindications

Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precautions and Side Effects

Complete blood cell counts should be made before and after therapy, especially if a second course is necessary.

Infrequent and minor side effects include: nausea, unpleasant taste, furry tongue, headache, darkened urine, diarrhea, dizziness, dryness of mouth or vagina, skin rash, dysuria, depression, insomnia, edema. Elimination of trichomonads may aggravate moniliasis.

Dosage Forms

Oral–250-mg.tablets/Vaginal–500-mg.inserts

SEARLE

Research in the Service of Medicine

BIOMEDICAL ENGINEERING COURSES OFFERED AT BIRMINGHAM CENTER

Courses in biomedical engineering, a fairly new and an expanding field, will be offered for the first time by the University of Alabama at the Center for Biomedical Engineering in Birmingham beginning this June.

Computer aids to medical diagnosis, ultrasonic therapy and surgery, computer simulation of heart action, coding of information for brain research are examples of studies being done in biomedical engineering in this country. At one institution an Arm-aid or powered splint which can move a paralyzed arm in the performance of normal actions has been developed. Other research in biomedical engineering is being done on human respiration and the nervous and circulatory systems.

A 12-month post-doctoral program in biomedical engineering will begin this June for medical scientists with an M. D., D. M. D., D. D. S., or Ph. D. degree. The program will include a concentrated study of engineering and the mathematics of biomedical engineering.

A graduate program in biomedical engineering will also be offered this fall for selected graduate students primarily with background in engineering and will lead to a Ph. D. in biomedical engineering. This program will emphasize the academic disciplines of medicine, dentistry, engineering, and the life sciences and their application to the solution of problems in medicine and dentistry.

A number of stipends covering tuition and living expenses will be available for the post-doctoral 12-month program and the graduate program for engineers. Applications for admission to the former will be accepted through May 15 and to the latter up to August 1. Requests for financial support for each of these programs are due by May 1. Those interested should write to the Center for Biomedical Engineering, University of Alabama, 1919 Eighth Avenue South, Birmingham, Alabama 35233.

DRUG ABUSE CONTROL AMENDMENTS OF 1965

for

health practitioners

From a pamphlet
Published By
American Pharmaceutical Association
2215 Constitution Avenue, N. W.
Washington, D. C. 20037

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After more than a decade of proposals and hearings, the Drug Abuse Control Amendments of 1965 establish special controls for depressant and stimulant drugs. Practitioners of the health professions know the measure as HR 2 by Representative Harris (89th Congress), the Dodd bill (88th and 87th Congresses), after its sponsor Senator Dodd, the Boggs bill in earlier Congresses, and the barbiturate and amphetamine proposal.

The Drug Abuse Control Amendments of 1965 amend the Federal Food, Drug, and Cosmetic Act and place additional controls over stimulant and depressant drugs through increased recordkeeping and inspection requirements providing control over intrastate traffic in these drugs, and making possession of stimulants and depressants except under specified conditions illegal. As is always the case, if a particular state law or regulation places more stringent controls over these drugs, those requirements must be complied with.

DRUGS COVERED

Barbiturates and amphetamines are specifically named in the law. However, the law speaks in terms of "depressant or stimulant drug" which also includes *any* drug which contains *any* quantity of a substance which is found to have a potential for abuse because of its depressant or stimulant effect on the central nervous system or its hallucinogenic ef-

(Continued on Page 929)

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Pentid-Sulfas for Syrup is a real knock-out when it comes to good taste. And, with a single prescription, you provide an anti-infective that combats both gram-positive and gram-negative bacteria. Notable for its economy, Pentid-Sulfas for Syrup is everybody's choice, patient, parent and physician.

Contraindications: Contraindicated in patients sensitive to sulfa or penicillin, pregnant females at term, premature infants, newborns during first week of life. **Precautions:** Watch for hypersensitivity reactions and overgrowth of nonsusceptible organisms. Observe usual precautions for sulfonamide therapy: adequate fluid intake; force fluids if urine volume is low; maintain urinary pH of 7 or higher; use only after critical appraisal in patients with liver or renal damage, urinary obstruction, blood dyscrasias. **Adverse Reactions:** Anaphylactoid shock (rare), G.I. disturbances, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, urticaria, purpura, hematuria, crystalluria, conjunctival and scleral varicula, petechiae may occur. **Dosage:** Daily pediatric dosage should supply 65-100 mg. trisulfapyrimidines per pound body weight in divided doses q. 4 to 6 h. **Supply:** Pentid-Sulfas for Syrup when prepared, provides 80 cc. (16 doses) or 150 cc. (30 doses) of fruit-flavored syrup providing in each 5 cc. teaspoonful 125 mg. (200,000 u.) potassium penicillin G and 167 mg. each of sulfadiazine, sulfamethazine, and sulfamerazine.

Now . . . **NEW PENTID® '400'—SULFAS FOR SYRUP** (buffered penicillin powder with sulfadiazine, sulfamethazine, and sulfamerazine each 5 cc. providing 250 mg. [400,000 units] potassium penicillin G and 167 mg. each of sulfadiazine, sulfamethazine, and sulfamerazine). Available in 16-dose (80 cc.) and 30-dose (150 cc.) bottles.

For full information, see Product Brief.

SQUIBB Squibb Quality—the Priceless Ingredient

(Continued from Page 926)

fect. Thus, the Secretary of Health, Education, and Welfare can bring additional drugs under the controls of the law by regulation. He may also exempt drugs which would otherwise be included within the literal language of the law when the controls are not necessary for the protection of public health. HEW Under Secretary Wilbur Cohen revealed that the Department has been reviewing additional drugs with a view to having necessary regulations promulgated by the date the bill takes effect—February 1, 1966.

FEDERAL REGISTRATION

Manufacturers, compounders, and processors and other firms already registered under the Drug Amendments of 1962 are required to indicate whether they are producing or distributing stimulant and depressant drugs in their registration statement. The act does add wholesalers, jobbers, and distributors of stimulant and depressant drugs only to the list of firms which must register. Wholesalers and jobbers were exempted from the registration under the Drug Amendments of 1962.

Wholesaling, jobbing, or distributing is defined as selling any depressant or stimulant drug to "any person who is not the ultimate user or consumer." The Report of the House Committee on Interstate and Foreign Commerce pointed out that pharmacies maintained in conformance with applicable state laws are exempted from the registration requirement.

Presumably, pharmacists who occasionally furnish a medical practitioner with office supplies or a fellow pharmacist with supplies to replenish his stock pending receipt of an order from a manufacturer or a wholesaler would not have to register; however, a pharmacist regularly engaged in wholesaling office supplies to physicians or dispensing stocks to other pharmacists would be required to register.

Since it is clear that the law contemplates a *complete and accurate* record, the pharmacist must indicate the name and address of the pharmacist or physician to whom he delivered the supply, the kind and quantity of the drugs involved. The pharmacist (or the physician if he otherwise must keep records under the law) receiving the drugs must also make a record showing the name of the pharmacist from whom received, the kind and quantity of drugs involved, and the date. No registration number is required because the law speaks of "the registration number, *if any*, . ." and pharmacies are not required to register with the HEW Secretary.

RECORDS

The Senate Committee on Labor and Public Welfare Report notes the intention to "establish controls upon the distribution of depressant and stimulant drugs throughout the chain of distribution, from the basic manufacturer to . . . the ultimate consumer." Each person handling stimulant and depressant drugs must prepare a complete inventory of all stocks on hand as of the effective date of the legislation—February 1, 1966—and keep the inventory for at least three years. Thereafter, a record must be maintained.

FOR STIMULANT AND DEPRESSANT DRUGS RECEIVED

- the kind and quantity of the drug
- the name, address, and registration number (assigned by HEW) of the person from whom received
- the date of the transaction.

FOR STIMULANT AND DEPRESSANT DRUGS DISPENSED

- the kind and quantity of the drug dispensed or otherwise disposed of
- the name, address, and registration number (generally not applicable for pharmacists or physicians) of the person obtaining the drug
- the date of the transaction.

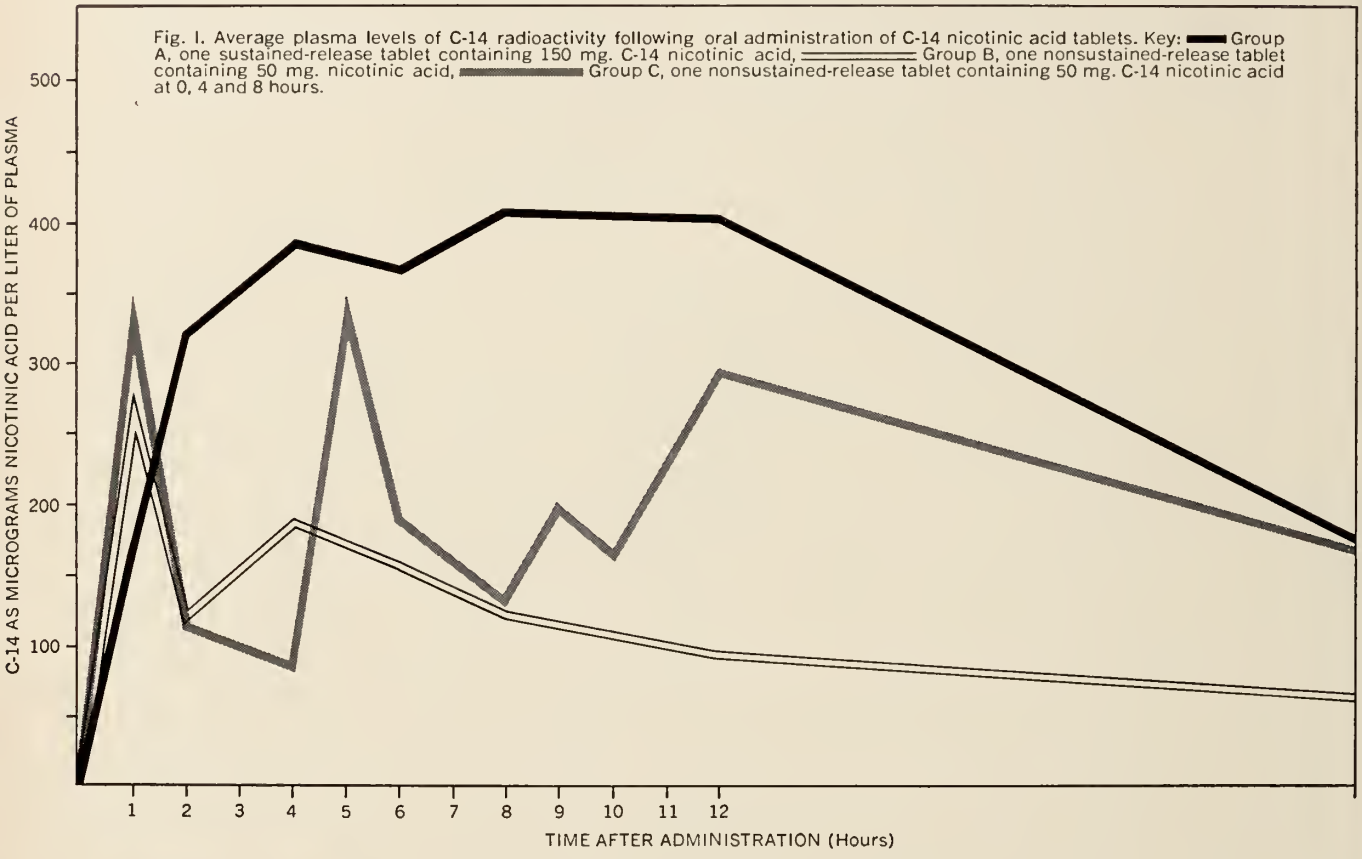
The records must be kept for three years unless state laws specify a *longer* period.

In most instances, the wholesaler or manufacturer invoice will comply with the receipt

(Continued on Page 932)

Sustained circulatory, respirator and cerebral stimulation for th

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

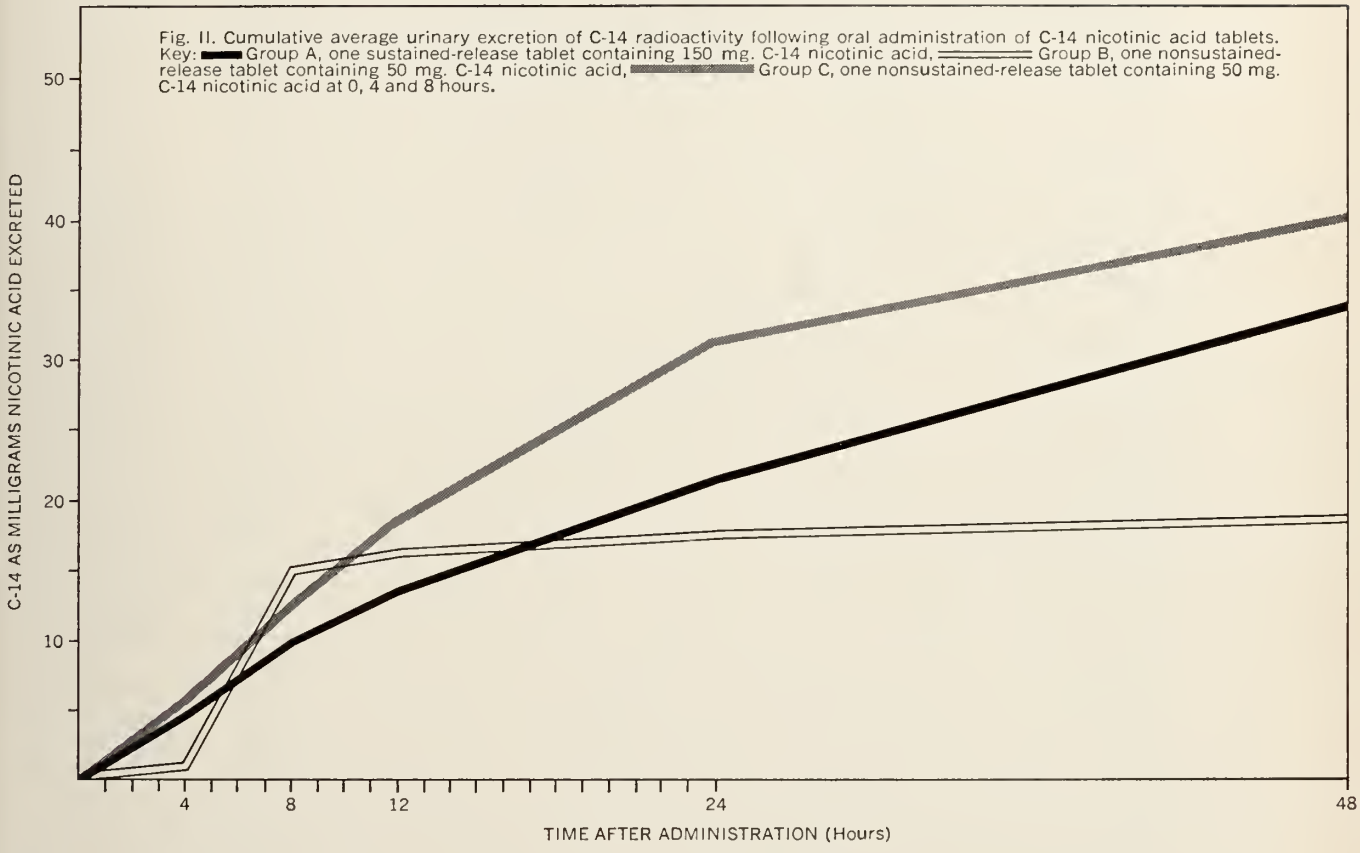
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ıged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Geroniazol® TT
nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

(Continued from Page 929)

record and the prescription file or patient chart with the dispensing record provided all the required information is available.

The law also provides that the HEW Secretary *shall* exempt from the provisions of the act by regulation

- any drug which may be sold over-the-counter
- combinations, which include one or more substances in such quantity, proportion, or concentration sufficient to prevent the stimulant or depressant drug from being ingested or absorbed in large enough quantities to cause the stimulant, depressant, or hallucinogenic effect.

INSPECTION

The record of receipt and disposition of depressant or stimulant drugs must be available for Food and Drug Administration employees to inspect. Pharmacists may maintain separate files in much the same manner as is now done for narcotics and where this is done, both the Senate and House Committee Reports make it clear that the inspection authority is limited to those separate files. However, the law specifically provides that no separate records need be kept and the records need not be in any special form. Normal business and pharmaceutical records are sufficient. In hospitals, patient order files and patient medical charts are sufficient.

In the debate on HR 2 on the floor of the House, a colloquy between Congressman Harris and Congressman Rogers of Florida pointed out that the inspection authority is not intended to confer any broader searches than the records for stimulant and depressant drugs. The Congressmen agreed that "this does not in effect authorize fishing expeditions" of the pharmacists' records.

In light of the prior Congressional denial of inspection authority to FDA agents, a Court will have to rule on whether an FDA inspector can utilize any evidence he may discover which does not relate to stimulant or depressant drugs where no separate records are maintained.

The law and both Committee reports emphasize that no special records need be maintained. This would be effectively nullified if evidence not relating to stimulant or depressant drugs was gathered under HR 2's inspection authority and later used against the pharmacist. This would force pharmacists to maintain separate records or relinquish rights they otherwise would have.

PROFESSIONAL SAMPLES AND PHYSICIANS

The House debate clearly indicates that a record must be made of professional samples of stimulant or depressant drugs obtained from medical representatives. Likewise, the medical representative has to keep a record of the disposition of any professional samples to pharmacists or physicians. This is to preclude the development of a gap in tracing the distribution of these drugs.

Physicians and other licensed practitioners who regularly engage in dispensing stimulant or depressant drugs to their patients and who make a charge for the drugs "either separately or together with charges for other professional services" must also keep records of receipt and disposition and make them available for inspection.

WHO MAY LAWFULLY POSSESS

Manufacturers, processors, and wholesale druggists dealing in stimulant or depressant drugs must register with the Secretary of HEW and may then lawfully possess the drugs in the usual course of their legitimate businesses. Common carriers and their employees are also authorized to possess the drugs in the usual course of their legitimate business. Stimulant and depressant drugs may lawfully be possessed by:

(1) pharmacies; (2) hospitals; (3) clinics; (4) public health agencies which maintain establishments in conformance with any applicable local laws regulating the practice of pharmacy and medicine; (5) physicians; (6)

(Continued on Page 935)



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Pentobarbital Sodium	25 mg.
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Butabarbital Sodium	7.5 mg.
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IN BRIEF:

EACH TABLET CONTAINS:

Pentobarbital Sodium	25 mg.
Secobarbital Sodium	25 mg.
Butabarbital Sodium	7.5 mg.
Phenobarbital	7.5 mg.

(WARNING: MAY BE HABIT FORMING)

Dosage: One or two tablets, one-half hour before bedtime.

Indications: For night-time sedation and refreshing sleep up to eight hours.

Contraindications: Patients sensitive to barbiturates. Use with caution in the presence of moderate to severe hepatic disease.

Supplied: Bottles of 100 tablets.

CAUTION: Federal law prohibits dispensing without a prescription.

ARMOUR PHARMACEUTICAL COMPANY
Chicago, Illinois, U.S.A.

(Continued from Page 932)

dentists, and other practitioners licensed by state law to administer depressant or stimulant drugs in their practices; (7) persons utilizing the drugs in research, teaching, or chemical analysis as long as the drugs are not for sale; (8) officers and employees of Federal, State, or local governments while acting in the course of their official duties; (9) nurses and other medical technicians who are under the supervision of a practitioner licensed by law to administer stimulant and depressant drugs while acting in the course of employment or occupation and not on their own account; (10) employees and agents of groups (1) through (7) noted above while acting in the course of their employment; (11) patients or a responsible member of the patient's household for his personal use or that of a member of his household or for administration to an animal owned by him or a member of his household.

PRESCRIPTION ORDERS AND RENEWALS

Prescription orders, to comply with record requirements, must contain the name and address of the patient and the date of issue which are the normal requirements for all prescription orders. There is no requirement that the prescription order must be written and signed by the prescriber; stimulant or depressant drugs may be dispensed on telephoned or oral instructions according to the usual practice However, *no prescription order can be renewed more than five times and no prescription order can be dispensed or renewed more than six months after the date of issue.* If the prescriber indicates a larger number of renewals or a longer duration, *the five renewals and six month limit still apply.* However, if there are no renewal instructions, then the prescription is non-renewable.

These requirements apply to all prescriptions after the effective date of the law regardless of the date on which they were written. After the five renewals or six months has elapsed, the physician may prescribe additional renewals for a like period.

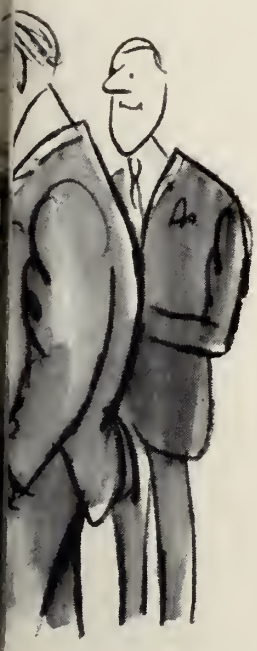
UNLAWFUL ACTS AND PENALTIES

Any person who violates the provisions of the act is subject to the penalties of the Federal Food, Drug, and Cosmetic Act. Conviction carries a punishment of imprisonment for not more than one year and a fine of not more than $1,000 or both for the first offense and imprisonment for not more than three years and a fine not more than $10,000 or both for subsequent offenses. An additional penalty has been added where stimulant or depressant drugs are sold to a person under 21 years of age. For a first offense, the punishment is imprisonment for not more than two years and a fine not more than $5,000 or both, and subsequent violations carry a penalty of not more than six years imprisonment and a fine of not more than $15,000 or both. Violations include:

- possession of stimulant or depressant drugs except as authorized in the law;
- failure to prepare and keep an accurate record of receipt and disposition of stimulant and depressant drugs;
- refusal of access to or copying of any of the required records;
- refusal to permit authorized inspections;
- dispensing or renewing any prescription more than six months after its date of issue or renewing the prescription order more than five times.

The Drug Abuse Control Amendments of 1965 also permit FDA agents who have special authorization to carry firearms, execute and serve search warrants and arrest warrants, execute seizures, and make arrests without warrants for offenses committed in the agent's presence.


SAIOH



Well, Doctor Cunningham, I was just telling Herbert I should talk to you about my cough. It comes from down here and...

Chances are the symptom recital may prove to be as difficult to control as the cough. If it's the useless, exhausting type of cough that often accompanies respiratory infection or allergy, you can provide prompt relief with Novahistine DH. Its decongestant-antitussive action controls frequency and intensity of cough spasms without abolishing cough reflex. And the fresh, grape flavor of Novahistine DH appeals to children and adults alike.

When your diagnosis is bronchitis, complicated by thick tenacious exudates, Novahistine Expectorant is particularly useful. It not only provides decongestive action and controls the cough, but also encourages expectoration, thus easing bronchial obstruction.

Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Ambulatory patients should be advised that drowsiness may result. Continuous dosage over an extended period is contraindicated since codeine phosphate may cause addiction.

Each 5 ml. teaspoonful of Novahistine DH contains codeine phosphate, 10 mg. (Warning: may be habit forming); phenylephrine hydrochloride, 10 mg.; chlorpheniramine maleate, 2 mg.; chloroform (approx.), 13.5 mg.; l-menthol, 1 mg. (Alcohol 5%). Each 5 ml. of Novahistine Expectorant contains the above ingredients and, in addition, glyceryl guaiacolate, 100 mg.

NOVAHISTINE® DH

NOVAHISTINE® EXPECTORANT

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis



Butazolidin® alka

phenylbutazone	100 mg.
dried aluminum hydroxide gel	100 mg.
magnesium trisilicate	150 mg.
homatropine methylbromide	1.25 mg.

In rheumatoid arthritis—effective therapy with minimal chance of G-I upset

Therapeutic Effects
Fifty to 75% of patients obtain major relief of arthritic symptoms, as reported by numerous clinicians. In addition, the problem of gastric upset—a major problem with certain other oral antiarthritic agents—is minimized by the presence of antacids and an antispasmodic in the formulation.

Improvement is generally seen within 3 to 4 days, and trial therapy need not be continued beyond a week. Relief of pain is followed quickly by resolution of inflammation and improved joint function. Relief of symptoms is often accompanied by increased appetite, gain in weight and an improved sense of well-being.

The initial response is usually maintained without dosage increases; indeed, initial dosage is often reduced for maintenance purposes.

Salicylate or steroid therapy can usually be diminished or, in some instances, eliminated.

Contraindications
Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage in Rheumatoid Arthritis
Initial: 3 to 6 capsules daily in divided dose. It is usually unnecessary to exceed 4 capsules daily. A trial period of 1 week is adequate to determine response; in the absence of favorable response, discontinue.

Maintenance: An effective level is often achieved with 1 to 2 capsules daily; do not exceed 4 daily.

Also available:
Butazolidin®, phenylbutazone
Tablets of 100 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

Geigy

Alabama Department of Public Health

SHELLFISH LABORATORIES—WHY TWO?

Within the last few years, a question has been raised over why it is necessary to have both a state and federal shellfish laboratory in the State of Alabama.

The laboratories are distinctly separate both in purpose and function, and seldom, if at all, do the responsibilities of each overlap.

The federal facility is concerned primarily with shellfish research for the benefit of all gulf states while the state laboratory is responsible for inspecting and determining the quality of oysters from Mobile bay.

The Alabama laboratory located at Mobile County Health Department performs four major functions.

The first is assisting in the certification of oyster growing areas. When the pollution of Mobile bay increases, a rise in the bacterial count of the oyster growing water occurs. If the bacterial count exceeds established limits, the ingestion of oysters by humans could be harmful. If this happens, the oyster beds are closed in the contaminated area and no harvesting is allowed until the count declines.

Another duty of the state laboratory is the sampling of oysters at wholesale distribution facilities. Periodic tests are conducted by the state laboratory to determine if certain standards are being met. If the oysters are not of the proper quality, the lot is subject to confiscation and shipment is not allowed. Certification by the laboratory and sanitary inspector guarantees quality of the product when shipped across state lines.

Checking samples gathered at the retail outlets is also a responsibility of the state laboratory. After testing, if the bacterial count is too high, the oysters are removed from the shelves and purchase by the public is prohibited.

Water content of the oyster and the container is also checked. If the quantity of water is found to exceed established limits, the entire lot of oysters is returned to the processor for re-packing.

Operational investigations are carried on by the state laboratory, but only for problems peculiar to Alabama. Research is not the primary purpose of the State Shellfish Laboratory.

The federal laboratory, located at Dauphin Island, is charged with the responsibility of conducting bivalve shellfish research.

The principal areas of research relate to pollutants (chemical and microbiological) in coastal estuaries; the mechanisms governing the accumulation and retention of pollutants by shellfish; perfection of processes which may free shellfish of contaminants and methodology to detect and measure the presence of biologically active substances in shellfish.

(Continued on Page 941)

single-dose vials for convenient and economical polio immunization



ORIMUNE® TRIVALENT
POLIOVIRUS VACCINE, LIVE, ORAL SABIN STRAINS TYPES 1,2 and 3

Fast, simple administration—and economy for the patient—make the new 0.5 cc single-dose vial of ORIMUNE Trivalent ideal for private practice. (Packaged 5 to a box with 5 sterilized disposable droppers for your convenience.) (Also available in 2 cc and 2 drop dosage forms.)

Only 2 doses required for complete, initial immunization for patients more than a year old. *Effectiveness*—may be expected to confer active immunity against all three types of poliovirus infection in at least ninety percent of susceptibles only if given at full dosage, as directed. No characteristic *side effects* have been reported. There are, however, certain *contraindications.* These are, broadly: acute illness, conditions which may adversely affect immune response, and advanced debilitated states. In these, vaccination should be postponed until after recovery.

In infants vaccination should not be commenced before the sixth week of life. Do not give to patients with viral disease, or if there is persistent diarrhea or vomiting. ORIMUNE and live virus measles vaccine should be given separately.

Dosage—initial immunization: two doses each given orally at least 8 weeks apart. (Give a third dose to infants at 10-12 months.) Booster immunization: one dose, given orally. See package literature for full directions.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York 660-6—3761 Lederle

SHELLFISH LABORATORIES

(Continued from Page 939)

Basically, the federal laboratory is a blending of applied research with the necessary articulation of chemical microbiological and marine sciences.

In addition to its research function, the federal laboratory also provides skilled technical assistance to the gulf states shellfish sanitation control agencies on some shellfish sanitation problems and in some areas of research in which a State may not be well equipped.

Resources of the federal laboratory are also available for training of State sanitation specialists in new laboratory and field techniques.

The federal laboratory works in four ways to safeguard consumers of shellfish.

The first is to provide information and methods to the States on ways of preventing contamination.

The second is to devise methods to protect against chance contamination of shellfish by the development of depuration or shellfish-purification methods.

The third is to devise new methods and procedures in shellfish sanitation and in public health control of this food, and the fourth, through training and technical assistance programs, make available to State and Federal control agencies and industry the knowledge gained through research.

The ultimate goal of both the state and federal laboratories is the production of safe, wholesome seafood.

Hill Crest
HOSPITAL
(Formerly Hill Crest Sanitarium)

Our 40th Year of Service

7000 5TH AVENUE SOUTH
Box 2896, Woodlawn Station
Birmingham, Alabama 35212
Phone: 205 - 595-1151

A patient centered independent hospital for intensive treatment of nervous disorders . . .

Hill Crest Hospital was established in 1925 as Hill Crest Sanitarium to provide private psychiatric treatment of nervous or mental disorders. Individual patient care has been the theme during its 40 years of service.

Both male and female patients are accepted and departmentalized care is provided according to sex and the degree of illness.

In addition to the psychiatric staff, consultants are available in all medical specialities.



MEDICAL DIRECTOR:
James A. Becton, M.D., F.A.P.A.

CLINICAL DIRECTORS:
James K. Ward, M.D., F.A.P.A.
Hardin M. Ritchey, M.D., F.A.P.A.

HILL CREST is a member of:
AMERICAN HOSPITAL ASSOCIATION NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS . . . ALABAMA HOSPITAL ASSOCIATION . . . BIRMINGHAM REGIONAL HOSPITAL COUNCIL.

Hill Crest
HOSPITAL
BIRMINGHAM, ALABAMA

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

MARCH 1966

Examination for intestinal parasites	1,646
Examination for malaria	5
Salmonella & shigella (blood, feces, urine and other)	299
Examination for tubercle bacilli	4,612
Examinations for gonococci	2,168
Serological tests for syphilis	30,566
FTA	12
Darkfield	3
Brucella	1
General Bacteriology (cultures for isolation and confirmation)	31
Staphylococcus (cultures for isolation and confirmation)	260
Examinations for diphtheria	34
Streptococci examinations	2,465
Mycology	21
Agglutinations	36
Vincent's Infection	3
Complement Fixation tests	615
Tests for Phenylketonuria (PKU)	6,257
Cytology	586
Water examinations	2,591
Milk and dairy products examinations	3,701
Sea food examinations	256
Examination for Negri bodies (smears & animal inoculations)	317
Virology	3
Miscellaneous	836
Total	57,324

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

CURRENT MORBIDITY STATISTICS

1966

	Feb.	Mar.	*E. E. Mar.
Tuberculosis	88	101	118
Syphilis	126	181	128
Gonorrhea	288	335	291
Chancroid	1	2	3
Typhoid fever	1	1	0
Undulant fever	0	0	0
Amebic dysentery	5	4	5
Scarlet fever & strep. throat	542	512	183
Diphtheria	0	2	2
Whooping cough	0	1	14
Meningitis	8	13	7
Tularemia	2	2	0
Tetanus	0	1	1
Poliomyelitis	0	0	0
Encephalitis	0	2	0
Smallpox	0	0	0
Measles	264	441	569
Chickenpox	242	137	237
Mumps	24	31	126
Infectious hepatitis	30	34	44
Typhus fever	0	0	0
Malaria	0	0	0
Cancer	413	437	647
Pellagra	3	0	0
Rheumatic fever	8	19	17
Rheumatic heart	19	29	28
Influenza	8,668	4,313	889
Pneumonia	559	548	289
Rabies—Human cases	0	0	0
Pos. animal heads	0	1	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.

BUREAU OF VITAL STATISTICS

PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA, 1964

Ralph W. Roberts, M. S., Director

Live Births / Deaths / Causes of Death	Number Recorded			Rates*		
	Prov. 1965	Final 1964	Average 1959-1963	Prov. 1965	Final 1964	Average 1959-1963
Live Births	69,902	76,111	79,150	20.1	22.1	23.9
Deaths	32,164	31,545	30,117	9.2	9.2	9.1
Fetal Deaths	1,459	1,549	1,686	20.4	19.9	20.9
Infant Deaths—						
under one month	1,371	1,580	1,657	19.6	20.8	20.9
under one year	2,107	2,377	2,501	30.1	31.2	31.6
Maternal Deaths	36	55	60	5.0	7.1	7.4
Causes of Death						
Tuberculosis, 001-019	252	246	280	7.2	7.2	8.5
Syphilis, 020-029	32	46	51	0.9	1.3	1.5
Dysentery, 045-048	5	9	13	0.1	0.3	0.4
Diphtheria, 055	5	3	5	0.1	0.1	0.2
Whooping cough, 056	4	8	7	0.1	0.2	0.2
Meningococcal infections, 057	21	23	17	0.6	0.7	0.5
Poliomyelitis, 080, 081	2	3	5	0.1	0.1	0.2
Measles, 085	12	13	11	0.3	0.4	0.3
Malignant neoplasms, 140-205	4,235	4,225	3,900	121.7	122.9	118.0
Diabetes mellitus, 260	552	455	442	15.9	13.2	13.4
Pellagra, 281	2	2	5	0.1	0.1	0.2
Vascular lesions of central nervous system, 330-334	4,493	4,403	4,196	129.1	128.0	126.9
Rheumatic fever, 400-402	16	18	26	0.5	0.5	0.8
Diseases of the heart, 410-443	10,477	10,440	10,059	301.0	303.6	304.3
Hypertension with heart disease, 440-443	1,361	1,445	1,722	39.1	42.0	52.1
Diseases of the arteries, 450-456	803	698	681	23.1	20.3	20.6
Influenza, 480-483	89	55	193	2.6	1.6	5.8
Pneumonia, all forms, 490-493	1,022	914	906	29.4	26.5	27.4
Bronchitis, 500-502	76	61	64	2.2	1.8	1.9
Appendicitis, 550-553	15	39	32	0.4	1.1	1.0
Intestinal obstruction and hernia, 560, 561, 570	158	155	148	4.5	4.5	4.5
Gastro-enteritis and colitis, under 2, 571.0, 764	93	117	132	2.7	3.4	4.0
Cirrhosis of liver, 581	226	205	197	6.5	6.0	6.0
Diseases of pregnancy and childbirth, 640-689	36	55	60	5.0	7.1	7.4
Congenital malformations, 750-759	342	405	390	4.9	5.3	4.9
Immaturity at birth, 774-776	383	476	543	5.5	6.2	6.9
Accidents, total, 800-962	2,397	2,199	2,057	68.9	63.9	62.2
Motor vehicle accidents, 810-835, 960	1,257	1,070	954	36.1	31.1	28.9
All other defined causes	4,636	4,897	4,403	133.2	142.4	132.8
Ill-defined and unknown causes, 780-793, 795	1,780	1,655	1,294	51.1	48.1	39.1

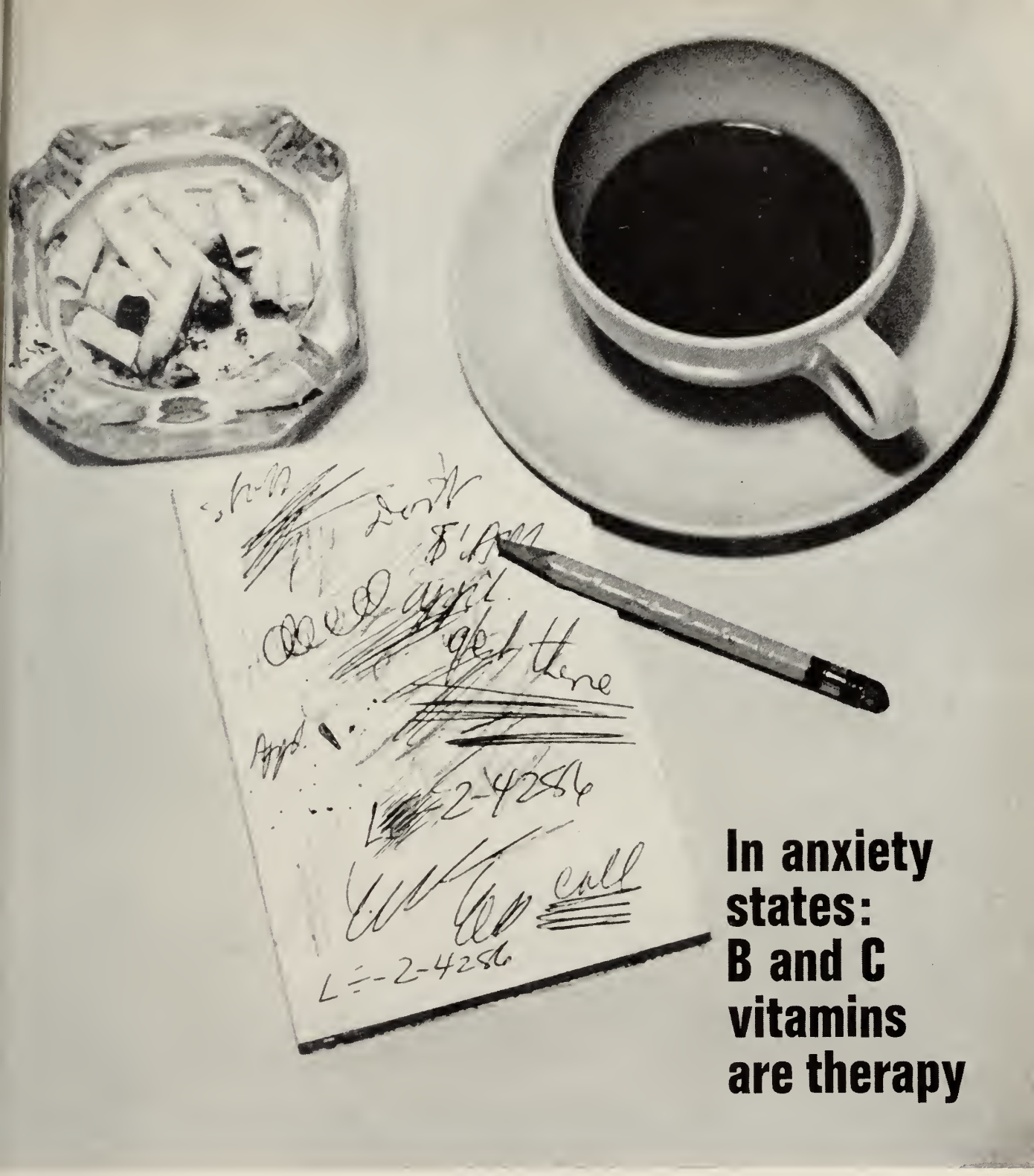
*Rates: Birth and death—per 1,000 population

Infant deaths—per 1,000 live births

Fetal deaths—per 1,000 deliveries

Maternal deaths—per 10,000 deliveries

Deaths from specified causes—per 100,000 population



In anxiety states: B and C vitamins are therapy

Stress formula vitamins are an important supportive measure in maintaining the nutritional status of the emotionally disturbed patient. With STRESSCAPS, B and C vitamins are present in therapeutic amounts to meet increased metabolic demands. Patients with anxiety, and many others undergoing physiologic stress, may benefit from vitamin therapy with STRESSCAPS.

Each capsule contains:	
Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

STRESSCAPS®

FOR PROFESSIONAL RECOMMENDATION ONLY

Stress Formula Vitamins Lederle

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

8241-4


Treat his
bacterial
upper respiratory
infection with tetracycline, but also consider relief of his
pain, headache, fever, malaise.

Effectively combat bacterial infection and maintain relief of respiratory symptoms

Tetrex®-APC

with Bristamin®

(tetracycline phosphate complex with analgesics and antihistamine)

The advantages of Tetrex® (tetracycline phosphate complex). It contains the basic tetracycline which is less bound to serum protein than is demethylchlortetracycline[1]. (It puts a higher percentage of active antibiotic into the blood.) Its basic tetracycline is also better tolerated than oxy- or demethylchlortetracycline.[2,3] *Unlike demethylchlortetracycline,[4] no cases of photodynamic skin reaction have been reported with Tetrex (tetracycline phosphate complex).*

with the benefits of APC and Bristamin (phenyltoloxamine citrate). Traditional APC provides predictable relief of pain, fever and malaise in acute respiratory infections, while the phenyltoloxamine citrate—notable for its effective histamine-blocking action with minimal drowsiness—adds relief of watering eyes, rhinorrhea, congestion and "tight" chest symptoms.

References: 1. Roberts, C.E., Jr.; Perry, D.M.; Kuharic, H.A., and Kirby, W.M.M.: Arch. Int. Med. *107*:204 (Feb.) 1961. 2. Dowling, H.F.; Lepper, M.H., and Jackson, G.G.: Clin. Pharmacol. & Therap. *3*:564 (Sept.-Oct.) 1962. 3. Editorial: Antibiotics & Chemother. *11*:427 (July) 1961. 4. Baer, R.L., and Harber, L.C.: JAMA *192*:989 (June 14) 1965.

BRISTOL THERAPEUTIC SUMMARY. For complete information, consult Official Package Circular. *Indications:* Upper respiratory infections due to sensitive bacteria where concomitant symptomatic relief of fever, malaise and congestion is desired. *Contraindication:* A past history of hypersensitivity to one or more components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if discomfort occurs. No cases of photosensitivity have been reported with Tetrex (tetracycline phosphate complex). With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Antihistamines may cause drowsiness and patients should not perform tasks requiring mental alertness while taking this agent. Bacterial or mycotic superinfection may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for three months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis and allergic reactions may occur. *Usual Adult Dose:* Two capsules *q.i.d.* Continue therapy for at least 10 days in beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.

BRISTOL

BRISTOL LABORATORIES / Division of Bristol-Myers Co., Syracuse, New York



NEW PRESIDENT-ELECT BRINGS WEALTH OF EXPERIENCE TO JOB

New president-elect of the Medical Association of the State of Alabama, destined by custom to move into the highest office one year hence, is Edward Bryce Robinson, M. D., of Birmingham.

Born September 6, 1910, at Selma, Ala., Dr. Robinson received his education in the public schools of Talladega, Ala., and was granted his B. S. Degree by Davidson College, Davidson, N. C., in 1932. He was awarded his M. D. Degree by Tulane University School of Medicine in 1936.

During the next three years he served his internship and residency in anesthesiology at Lloyd Noland Hospital, Fairfield, Ala., the hospital he now serves as medical director.

Shortly before his graduation from medical school Dr. Robinson was married to the former Margaret Allen Wallis. They have two daughters: Mrs. Margaret Robinson Northen and Mrs. Mary Robinson Somerville.

Dr. Robinson served in the Army Medical Corps during World War II from 1941 until 1946, attaining the rank of lieutenant colonel.

He brings with him to the office of president-elect a broad experience in medical association affairs. He is a counsellor of MASA and delegate to the American Medical Association, serving since 1963 as a member of the highly-important Council on Medical Education and Hospitals. During that same year he served also as president of the Jefferson County Medical Society and as president of



E. Bryce Robinson, Jr., M. D.



Dr. J. Paul Jones presides for the last time at Board of Censors meeting.



Board of Trustees puts finishing touches to Annual Reports on first day.



Dr. Ira Myers (left), Dr. John Chenault tackle finished reports.



Dr. W. S. Littlejohn, Dr. Paul Burleson muse over results.

the American Association of Medical Clinics.

Among his numerous other activities he has served on the Board of Directors of Blue Cross-Blue Shield of Alabama, the Hospital Licensure Advisory Board, the Visiting Nursing Association, the Disaster Committee of the Jefferson County Chapter of the American Red Cross, and the Jefferson County Board of Health from 1950 to 1960.

He is a past president of the Birmingham Clinical Club and the Birmingham Surgical Society. He currently is president of the Lloyd Noland Foundation, Inc.

In addition to MASA and the Jefferson County Medical Society, Dr. Robinson is a member of the American Society of Anesthesiologists, the American Association of Medical Clinics, a Fellow of the American College of Anesthesiologists and a diplomate of the American Board of Anesthesiology.

(Continued on Page 948)

PICTURE REPORT ON ANNUAL SESSION



Dr. Ross C. Kory and Dr. W. J. Tally, participants in Alabama Thoracic Society program (left).



Mrs. Elizabeth Horne, Community Organizer for Emphysema Research Programs with Dr. J. D. Rayfield, Sylacauga, Vice President





Time for relaxation after first day's session at Municipal Auditorium







the sedentary life is often the seat of low back pain

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strains

SOMA®
(CARISOPRODOL)

Wallace Laboratories, Cranbury, N.J.
26S01J

PICTURE REPORT ON ANNUAL SESSION



Past Presidents and Fifty Year Club get together for breakfast.



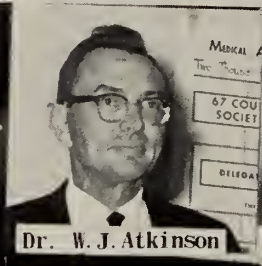
New members of Fifty Year Club with their certificates of recognition



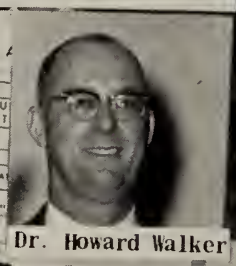
Secretary Smith presents Gorgas Award to Dr. Emmett Carmichael.



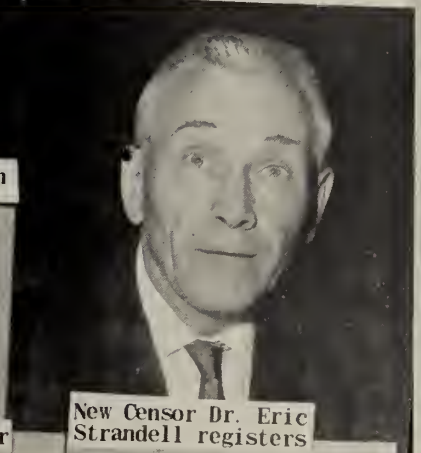
President Donald with Dr. James Hardy.



Dr. W. J. Atkinson



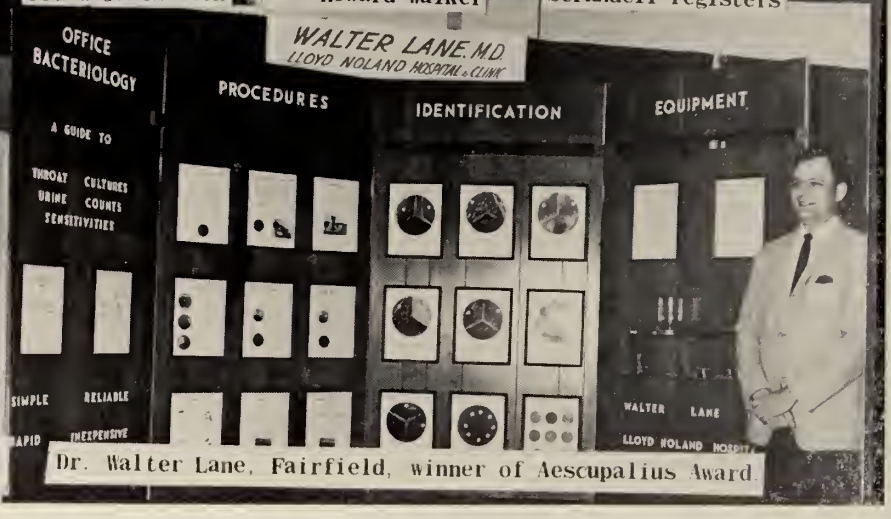
Dr. Howard Walker



New Censor Dr. Eric Strandell registers



One exhibitor refused to admit defeat.



Dr. Walter Lane, Fairfield, winner of Aescupalius Award.



AMA President-Elect, Dr. Charles Hudson, Dr. Durward Hall and Dr. James Dumas at ALAPAC Luncheon.



Independent Gubernatorial candidate, Dr. Carl Robinson (right) with Dr. O. Emfinger.



Country Club affair was a social high light.



Dean S. Richardson Hill receives AMA-ERF contribution of $11,029.10 from President Donald.

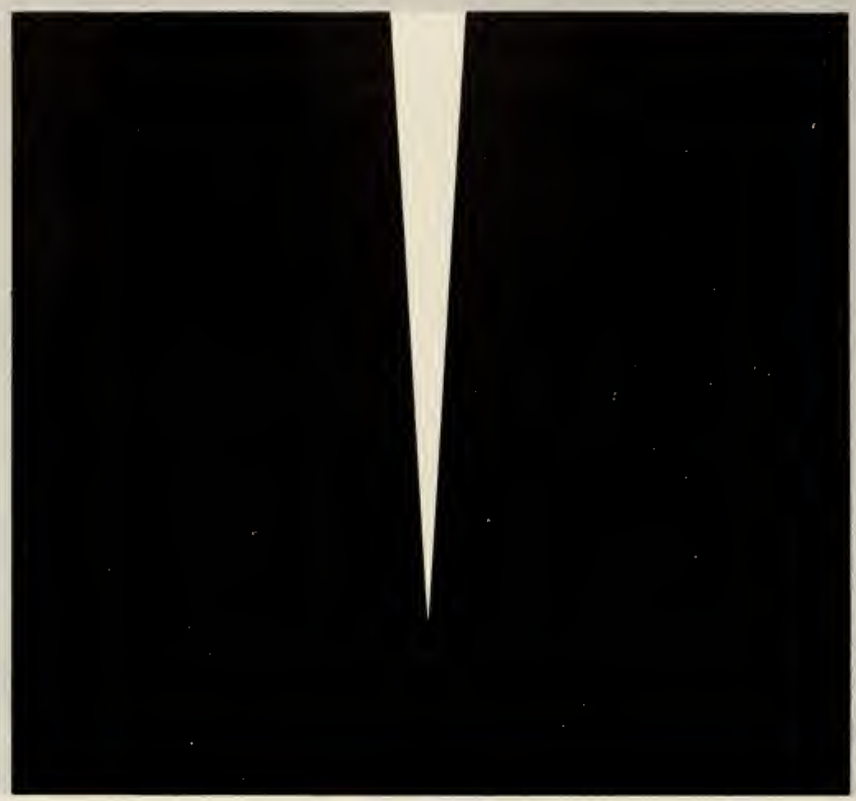


Dr. J. S. Tarwater presented the Sanders Award.

PICTURE REPORT ON ANNUAL SESSION



Association members sitting as Board of Health, study annual reports.



incisive

A good way to describe 'Stelazine'. It's different from the tranquilizers that sedate and dull your anxious patients. Its antianxiety effect is direct. On 'Stelazine', your patients can be calmed yet remain alert.

And 'Stelazine' offers additional benefits. Dependence has not been reported. At low doses, side effects are minimal. Its b.i.d. dosage is convenient and economical.

Stelazine®

brand of **trifluoperazine**

Indications: Symptoms of excessive anxiety. *Contraindicated* in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects,* usually dose related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems. Before prescribing, see SK&F product Prescribing Information.

Smith Kline & French Laboratories, Philadelphia

SK&F



brings peace to the hyperactive colon

CANTIL®
(mepenzolate bromide)

helps restore normal motility and tone

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects . . . Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1. Riese, J. A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

LAKESIDE LABORATORIES, INC. Milwaukee, Wisconsin 53201

LAKESIDE

PRODUCTS
FOR PATIENTS
YOU SEE
EVERY DAY

DACTILASE®

Each tablet contains:
Dactil® (piperidolate hydrochloride), 50 mg.;
Standardized cellulolytic* enzyme, 2 mg.;
Standardized amylolytic enzyme, 15 mg.;
Standardized proteolytic enzyme, 10 mg.;
Pancreatin 3X** (source of lipolytic activity), 100 mg.; Taurocholic acid, 15 mg.

*Need in human nutrition not established.
**As acid resistant granules equivalent in activity to 300 mg. Pancreatin N.F.



In chronic or acute indigestion, fluttery, gassy stomachs obtain prompt, gratifying relief through the antispasmodic, surface anesthetic and enzymatic activity of Dactilase. Dactilase decreases hypermotility and pain and reduces the production of gas. Dactilase does not induce stasis, but helps restore normal tone. It has little or no effect on enzyme secretions, but *adds* enzymes, thus contributing to the digestive efficiency of the patient.

Side Effects and Contraindications: Dactilase is almost entirely free of side effects. However, it should be withheld in glaucoma and in jaundice due to complete biliary obstruction.

Administration and Dosage: One tablet with, or immediately following, each meal. Tablets should be swallowed whole.

Supplied: Bottles of 60 and 250.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE | PRODUCTS FOR PATIENTS YOU SEE EVERY DAY

For cold hands and feet, nothing beats hot stoves—but they *are* awkward to carry around. Now Gerilid, in good-tasting take-along chewable tablets can provide rapid vasodilation of peripheral circulation, bringing real warmth to the extremities and decreasing sensitivity to sudden temperature change. Patients *like* Gerilid and *know* they are getting relief.



GERILID™

Each chewable tablet contains:
nicotinic acid (niacin) 75 mg. and
aminoacetic acid (glycine) 750 mg.

Administration and Dosage: One or two chewable tablets 3 times a day before meals. If flushing is objectionable, dosage may be lowered. However, tolerance to flushing usually develops without loss of efficacy in regard to vasodilation. The recommended dosage should not be exceeded.

Side effects: Occasional lightheadedness or transient itching which may disappear with continued use. There are no known contraindications; however, caution is advised when there is a concomitant administration of a coronary vasodilator.

Supplied: Packages of 50 chewable tablets.

Also available in liquid form as Geriliquid®, in bottles of 8 and 16 ounces.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE

PRODUCTS
FOR PATIENTS
YOU SEE
EVERY DAY

Obstetrical or post—surgical patients requiring a dependable increase in hemoglobin will receive as much iron (250 mg. in a 5 cc. ampul) as in one pint of blood. Imferon (iron dextran injection) is less expensive and it avoids the well-recognized hazards of whole blood transfusion. When patients cannot—or cannot be relied upon to—take oral iron, Imferon (iron dextran injection) will rapidly supply needed iron for reserve stores.



IMFERON®
(iron dextran injection)

IN BRIEF: ACTION AND USES: A single dose of Imferon (iron dextran injection) will measurably begin to raise hemoglobin and a complete course of therapy will effectively rebuild iron reserves. The drug is indicated only for specifically-diagnosed cases of iron deficiency anemia and then only when oral administration of iron is ineffective or impractical. Such iron deficiency may include: patients in the last trimester of pregnancy; patients with gastrointestinal disease or those recovering from gastrointestinal surgery; patients with chronic bleeding with continual and extensive iron losses not rapidly replenishable with oral iron; patients intolerant of blood transfusion as a *source of iron;* infants with hypochromic anemia; patients who cannot be relied upon to take oral iron.

COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

CONTRAINDICATIONS: Imferon (iron dextran injection) is contraindicated in patients sensitive to iron dextran complex. Since its use is intended for the treatment of iron deficiency anemia only it is contraindicated in other anemias.

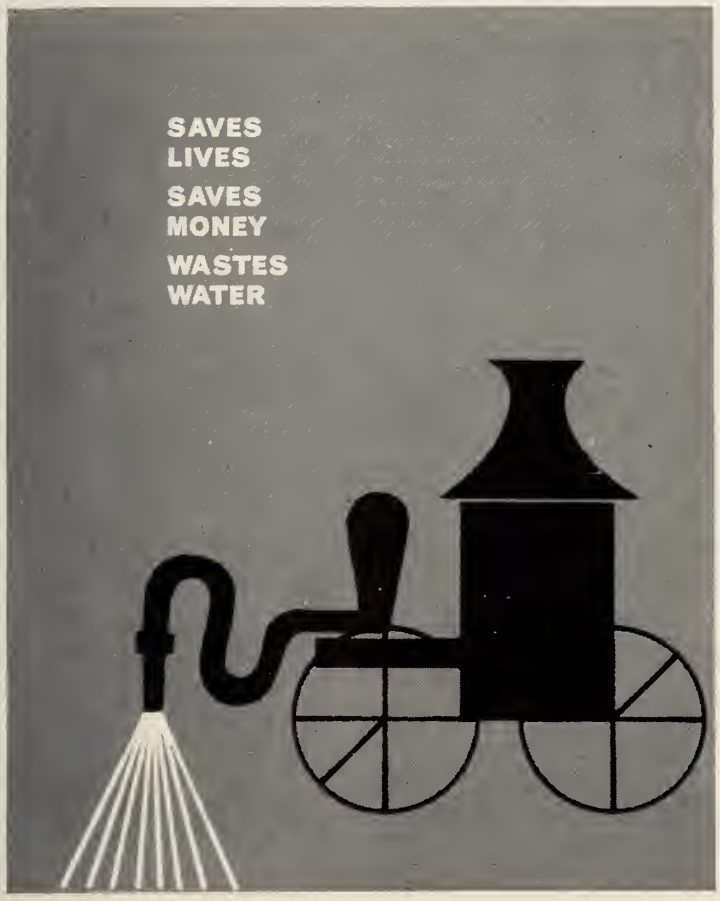
CARCINOGENICITY POTENTIAL: Using relatively massive doses, Imferon (iron dextran injection) has been shown to produce sarcoma in rats, mice and rabbits and possibly in hamsters, but not in guinea pigs. The risk of carcinogenesis, if any in man, following recommended therapy with Imferon (iron dextran injection) appears to be extremely small.

SUPPLIED: 2 cc. ampuls, boxes of 10; 5 cc. ampuls, boxes of 4; 10 cc. multiple dose vials.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE | PRODUCTS FOR PATIENTS YOU SEE EVERY DAY

METAHYDRIN (trichlormethiazide) is prescribed by physicians because it not only approximates the diuretic efficacy of parenteral meralluride injection . . . but, *it is the least expensive of all "brand-name" thiazides*. Therefore, when you prescribe METAHYDRIN (trichlormethiazide) your patients receive the thiazide diuretic that removes a little more salt and water than earlier thiazides, with relatively less loss of potassium . . . and, it's therapy they can more easily afford . . . *only pennies a day*.



METAHYDRIN®

(trichlormethiazide)

oral diuretic

Dosage: One 2 or 4 mg. tablet once or twice daily.

Precautions: As with all effective diuretics, vigorous therapy may produce electrolyte depletion. Patients with severely reduced renal function should be observed carefully since thiazides may be contraindicated. Care should be taken with patients predisposed to diabetes or gout. Patients with a tendency to potassium deficiency, as in hepatic cirrhosis or diarrheal syndromes, or those under therapy with digitalis, ACTH, or certain adrenal steroids, also should be watched carefully.

Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

Contraindications: Complete renal shutdown; rising azotemia or development of hyperkalemia or acidosis in severe renal disease; demonstrated hypersensitivity.

How Supplied: Bottles of 100 and 1000 tablets.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE | PRODUCTS FOR PATIENTS YOU SEE EVERY DAY

Metatensin lowers blood pressure and keeps it low—effectively and economically. It combines reserpine with trichlormethiazide which affords more potent saluresis with less loss of potassium than from earlier thiazides. Reserpine contributes antihypertensive effect by relieving anxiety and tension. Metatensin is well-tolerated over long periods; with its effectiveness and economy it assures antihypertensive therapy you and your patients can stay with.

BRING IT DOWN AND KEEP IT DOWN



METATENSIN®

Each scored tablet contains:
METAHYDRIN® (trichlormethiazide)
2 mg. or 4 mg. and
Reserpine 0.1 mg.

Usual adult dose: One tablet twice daily. **Precautions and side effects:** Patients with hepatic cirrhosis or diarrheal syndromes, or under therapy with digitalis, ACTH, or potassium-losing steroids, should be observed for signs of hypokalemia. With thiazides, electrolyte depletion, diabetes, gout, granulopenia, nausea, pancreatitis, cholestatic jaundice, flushing, mild muscle cramps, constipation, photosensitivity, acute myopia, perimacular edema, paresthesias, neonatal bone marrow depression in infants of mothers who received thiazides during pregnancy, skin rash or purpura with or without thrombocytopenia, may occur. With reserpine, untoward effects may include depression, peptic ulcer and bronchial asthma. Withdraw medication at least 7 days prior to electroshock therapy, 2 weeks prior to elective surgery.

Contraindications: Complete renal shutdown, rising azotemia or development of hyperkalemia or acidosis in severe renal disease.

Supplied: Metatensin tablets, 2 mg., 4 mg.—bottles of 100 and 1000.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE | PRODUCTS FOR PATIENTS YOU SEE EVERY DAY



when the feeling of guilt overwhelms

NORPRAMIN®

(desipramine hydrochloride)

non-sedating · rapid-acting
ANTIDEPRESSANT

overcomes guilt, lifts depression, restores confidence

Feelings of guilt, worthlessness, emptiness and loss frequently characterize depression. Such feelings, along with insomnia, physical complaints, sadness, apprehension, and other symptoms of depression rapidly respond to Norpramin (desipramine hydrochloride). Improvement often begins in 2-5 days, sometimes in less. A few patients, sensitive to central nervous system stimulants may become restless as depression is lifted—in such cases dosage may be reduced or a tranquilizer added.

Indications: In depression of any kind—neurotic and psychotic depressive reactions; manic-depressive or involutional psychotic reactions. **Dosage:** Optimal results are obtained at a dosage of two 25 mg. tablets t.i.d. (150 mg./day). **Contraindications and Precautions:** Glaucoma, urethral or ureteral spasm, recent myocardial infarction, severe coronary heart disease and epilepsy. Should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Safety in human pregnancy has not been established. **Adverse Effects:** Side effects, usually mild may include: dry mouth, constipation, dizziness, palpitation, delayed urination, "bad taste," sensory illusion, tinnitus, agitation and stimulation, sweating, drowsiness, headache, orthostatic hypotension, flushing, nausea, cramps, weakness, blurred vision and mydriasis, rash, allergy, transient eosinophilia, granulopenia, altered liver function, ataxia and extrapyramidal signs. **Supplied:** Norpramin (desipramine hydrochloride) tablets of 25 mg., in bottles of 50, 500 and 1000.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE | PRODUCTS FOR PATIENTS YOU SEE EVERY DAY

In colicky infants Pediatric Piptal with Phenobarbital slows down spasm, diminishes pain and crying and improves feeding patterns. It permits sleep and rest for patient and family. The less than hypnotic amount of phenobarbital in the recommended dose affords a mild, calming action and enhances the antispasmodic action of Piptal (pipenzolate bromide). The latter drug, as reported in the medical literature, has a favorable ratio of effectiveness to side-effects which is unusual in anticholinergics and thus is particularly appropriate to pediatric use.



PEDIATRIC PIPTAL® WITH PHENOBARBITAL

each cc. contains 6 mg. phenobarbital (warning: may be habit forming); 4 mg. Piptal® (pipenzolate bromide), and 20% alcohol.

Pleasant-tasting Pediatric Piptal with Phenobarbital is miscible in milk, formulas and fruit juices, and may also be given by dropper directly on the infant's tongue. Dosage is 0.5 cc. 15 minutes before feeding; in severe cases, 1.0 cc. four times daily. High doses may occasionally cause constipation with tenesmus and, rarely, flushing without fever. It is contraindicated in bowel obstruction or sensitivity to phenobarbital or anticholinergics. Available in 30 cc. dropper bottles, droppers calibrated to deliver 0.5 cc.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

LAKESIDE

PRODUCTS
FOR PATIENTS
YOU SEE
EVERY DAY

STANDING COMMITTEES OF MASA

The following committee assignments for MASA were announced by President J. O. Finney, Sr., at the conclusion of the Annual Session:

Committee on Public Relations and Economics

C. A. Grote, Jr., Chairman, Huntsville ... 1969
*W. B. Cameron, Huntsville ... 1970
*Jack Brock, Dadeville ... 1970
*Ira B. Patton, Oneonta ... 1970
S. B. Word, Birmingham ... 1967
D. F. Sullivan, Mobile ... 1967
L. H. Clemmons, Cullman ... 1968
T. Riley Lumpkin, Tuskegee ... 1969
H. C. Mullins, Jr., Fairhope ... 1969
L. D. McLaughlin, Ozark ... 1970

(The President, President-Elect, Secretary, State Health Officer, and Vice President F. M. Phillippi, Jr., are ex-officio members.)

Committee on Medical Education and Hospitals

R. K. Oliver, Tuscaloosa ... 1967
Margaret S. Klapper, Birmingham ... 1968
W. B. Sorrell, Montgomery ... 1969
*Arthur M. Freeman, Jr., Birmingham ... 1970
*John S. Whitehead, Birmingham ... 1970

(The Dean of the Medical College of Alabama and Vice President S. J. Campbell are ex-officio members.)

Committee on Insurance

C. A. Lightcap, Chairman, Mobile ... 1968
*J. M. Morgan, Birmingham ... 1970
J. O. Morgan, Gadsden ... 1967
B. M. Carraway, Birmingham ... 1969
B. S. Henry, Russellville ... 1970
*Archie Hill Carmichael, Jr., Sheffield ... 1970

(President-Elect is an ex-officio member.)

Committee on Constitution and By-Laws

E. B. Glenn, Chairman, Birmingham ... 1970
*Richard A. Harris, Montgomery ... 1970
T. E. Bridges, Anniston ... 1967
J. A. Pennington, Whistler ... 1968
Hal Ferguson, Birmingham ... 1969

(The Chairman of the State Board of Censors, the Secretary, and Vice President W. B. Cameron are ex-officio members.)

Committee on Aging and the Indigent

J. G. Galbraith, Chm., Birmingham ... 1970
*S. N. Rumpanos, Mobile ... 1970
*W. E. White, Anniston ... 1970
Ira L. Myers, Montgomery ... 1967
J. J. Kirschenfeld, Montgomery ... 1967
J. O. Morgan, Gadsden ... 1968
B. R. Boshell, Birmingham ... 1968
J. Michaelson, Foley ... 1969
Luther Davis, Jr., Tuscaloosa ... 1969
E. R. Johnston, Birmingham ... 1970

(Vice President W. B. Cameron is an ex-officio member.)

Committee on Legislation

E. L. McCafferty, Jr., Chm., Mobile ... 1969
*Louis Johnson, Dothan ... 1970
*H. H. Hutchinson, Montgomery ... 1970
W. B. Virgin, Montgomery ... 1967
G. H. Stokes, Dothan ... 1967
*Charles H. Lupton, Jr., Birmingham ... 1970
J. F. Dumas, Mobile ... 1967
W. E. White, Anniston ... 1968
S. J. Campbell, Birmingham ... 1968
F. M. Phillippi, Jr., Brewton ... 1969
B. B. Jordan, Huntsville ... 1970

(The President, President-Elect, Secretary, Executive Secretary of the Association, State Health Officer, E. B. Glenn and Paul W. Burleson are ex-officio members.)

(Continued on Page 964)

When uncontrolled diarrhea brings a call for help

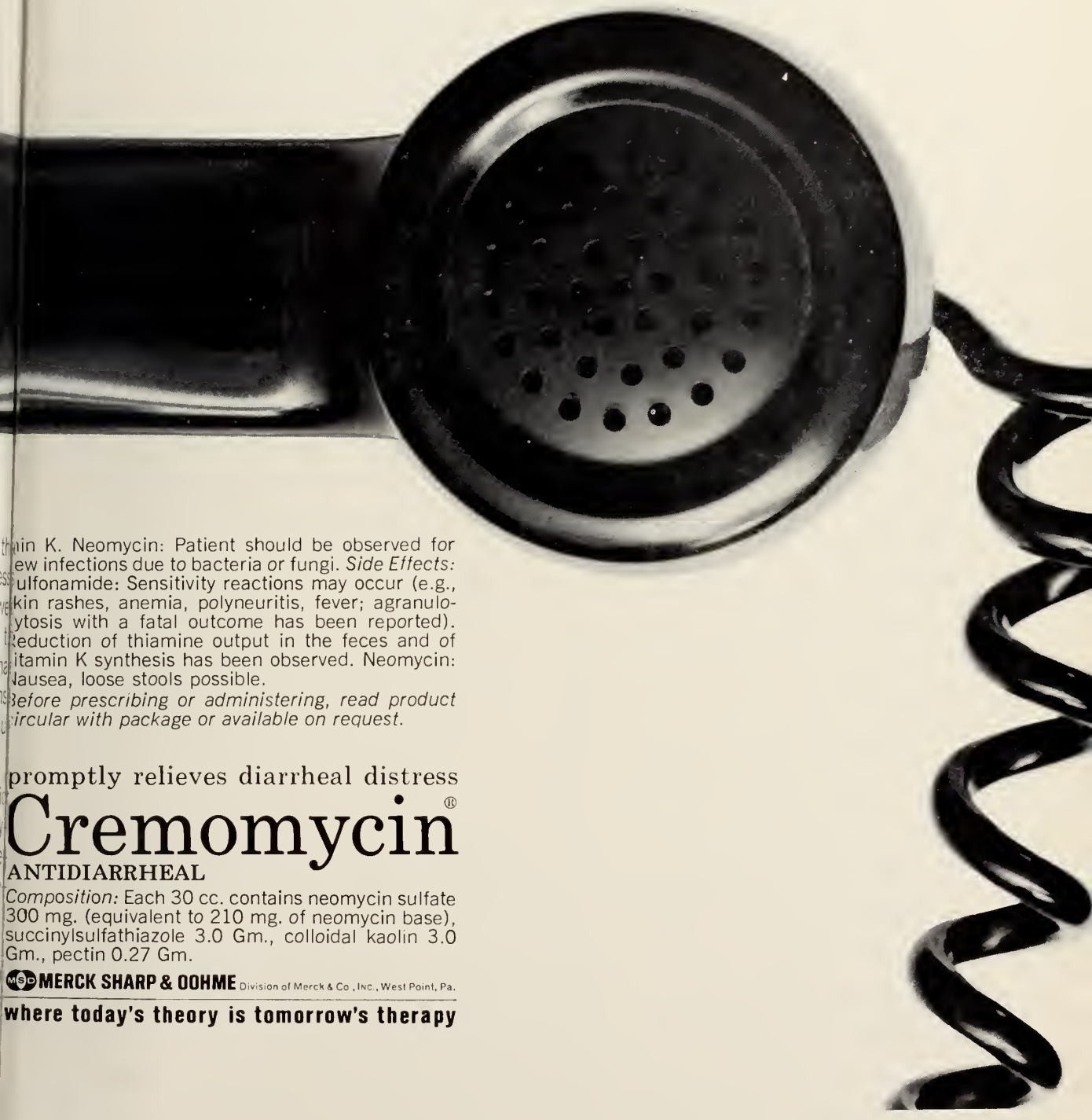


When the diarrhea sufferer has run th gamut of home remedies without success pleasant-tasting CREMOMYCIN can answe the call for help. It can be counted on t consolidate fluid stools, soothe intestina inflammation, inhibit enteric pathogens and detoxify putrefactive materials—usu ally within a few hours.

CREMOMYCIN combines the bacteriostatic agents, succinylsulfathiazole and neomy cin, with the adsorbent and protective de mulcents, kaolin and pectin, for compre hensive control of diarrhea.

Indications: Diarrhea. *Contraindications:* Kaolin Withhold if diverticulosis is present or suspected *Precautions:* Sulfonamide: Continued use requires supplementary administration of thiamine and vita

your ℞ for Cremomycin can provide relief



in K. Neomycin: Patient should be observed for ew infections due to bacteria or fungi. *Side Effects:* ulfonamide: Sensitivity reactions may occur (e.g., kin rashes, anemia, polyneuritis, fever; agranulo- ytosis with a fatal outcome has been reported). eduction of thiamine output in the feces and of itamin K synthesis has been observed. Neomycin: Nausea, loose stools possible.
Before prescribing or administering, read product circular with package or available on request.

promptly relieves diarrheal distress

Cremomycin®

ANTIDIARRHEAL

Composition: Each 30 cc. contains neomycin sulfate 300 mg. (equivalent to 210 mg. of neomycin base), succinylsulfathiazole 3.0 Gm., colloidal kaolin 3.0 Gm., pectin 0.27 Gm.

MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

STANDING COMMITTEES

(Continued from Page 961)

Committee on Maternal and Child Health

G. L. Wideman, Chm., Birmingham 1969
*Chester W. White, Jr., Birmingham 1970
W. A. Walker, Decatur 1967
J. H. French, Montgomery 1968
G. E. Cassady, Birmingham 1970

(The State Health Officer and Vice President S. J. Campbell are ex-officio members.)

Committee on Allied Medical Services

W. J. Atkinson, Jr., Chairman, Mobile 1967
*William Maddox, Birmingham 1970
C. E. Porter, Fairfield 1967
J. N. Sussex, Birmingham 1968
W. F. Little, Jr., Montgomery 1968
R. K. Oliver, Tuscaloosa 1968
J. S. Tarwater, Tuscaloosa 1969
A. A. Calix, Decatur 1969
S. S. Romendick, Mobile 1970

(Vice President G. H. Stokes is an ex-officio member.)

Grievance Committee

J. W. Simpson, Chairman, Birmingham 1967
H. E. Gray, Anniston 1966
M. Vaun Adams, Mobile 1968
J. G. Daves, Cullman 1969
E. B. Glenn, Birmingham 1970

(The President is an ex-officio member.)

Relative Value Index

*W. B. Crum, Chairman, Montgomery 1970
*Maurice C. Holcomb, Jr., Birmingham 1970
*Octavus McCrary Otts, Jr., Mobile 1970
S. W. Windham, Dothan 1967
J. M. Slaughter, Fairfield 1968
J. E. Welden, Birmingham 1968
E. E. Camp, Huntsville 1969
P. K. Burwell, Montgomery 1969
R. O. Harris, III, Mobile 1970
H. C. Byrne, Montgomery 1970

Alabama Hospital-Medical Council

E. Bryce Robinson, Jr., Chm., Fairfield 1967
*H. N. Webster, Jr., Mobile 1970
W. E. Lawrence, Birmingham 1968
H. G. Hodo, Jr., Fayette 1969
W. A. Edwards, Wetumpka 1970

(Vice President G. H. Stokes is an ex-officio member.)

Committee on Rural Health

Paul Nickerson, Chm., Sylacauga 1967
W. A. Walker, Decatur 1967
J. H. French, Montgomery 1968
G. E. Cassady, Birmingham 1970

(The State Health Officer and Vice President S. J. Campbell are ex-officio members.)

Blue Cross-Blue Shield

*E. B. Glenn, Chairman, Birmingham 1970
*C. K. Pitt, Decatur 1970
I. A. Koffler, Mobile 1967
J. W. Boggess, III, Guntersville 1967
R. O. Rutland, Jr., Fayette 1968
H. G. King, Tuscaloosa 1968

(The President is an ex-officio member.)

Advisory Committee of the Woman's Auxiliary

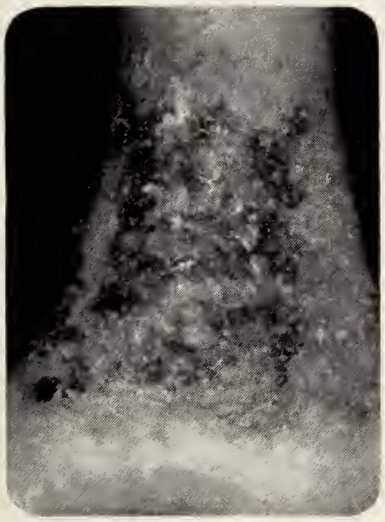
*William L. Smith, Chairman, Montgomery
*James C. Guin, Jr., Tuscaloosa
James K. V. Willson, Mobile
William G. Thuss, Sr., Birmingham
William D. Anderson, Tuscaloosa
L. H. Clemmons, Cullman

*New members or reappointments.

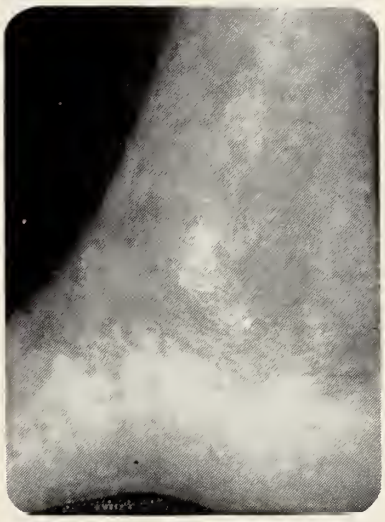
AMA DUES INCREASE ON APRIL MEETING AGENDA

One of the major issues which will come before the American Medical Association House of Delegates on June 26-30 in Chicago is a proposed increase in dues. As you probably have read, the AMA Board of Trustees has proposed to increase the annual membership from $45 to $70, an increase of $25. This increase would become effective January 1, 1967.

eczema: scourge of childhood



R. R., Age 11—Before treatment—atopic eczema of long standing



After treatment—with ARISTOCORT Topical Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of childhood eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

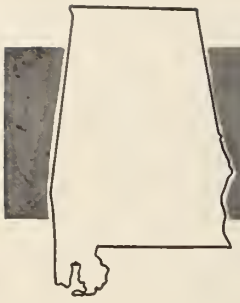
Packages: Tubes of 5 Gm. and 15 Gm.; ½ lb. jar.

PHOTOGRAPHS COURTESY OF M. M. NIERMAN, M.D.

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Big Job Lies Ahead In Civil Defense

By J. Frank Manderson, Director

Civil Defense Department

State of Alabama

There is no pleasant way to look at the possibility of a nuclear attack against these United States. But, until we are willing to seriously consider it, or think about it, we will never be prepared.

More and more people are realizing the necessity for a well-rounded Civil Defense program, one that can be incorporated into our day-to-day living.

Every day that we live there becomes a greater need for emergency capabilities; so, as you work from day to day for an effective Civil Defense program, you are doing something vitally important for the preservation of your city, county and State.

We have come a long way in Civil Defense but a big job lies ahead. We must work together to give our State and Nation the total defense program it needs. I am sure we will reach this objective with the help of those who are concerned.

Today, much knowledge of fallout, and how to cope with it, exists. It remains largely to get this vital information out to the public and enlist the cooperation of people in preparing protective measures for the possibility of radioactive fallout.

It is the concentrated, heavy fallout from a nuclear attack that we in Civil Defense worry about. Such fallout results when one or many nuclear detonations take place in such a way that the fireballs touch the ground and suck up thousands of tons of earth and debris into the radioactive fireball and mushroom of the blast. Fine and coarse material would be created, descending hundreds of miles downwind from the explosion. These granules would act as carriers for a relatively high level of radioactivity.



J. Frank Manderson

One form of radiation—beta radiation—would be capable of causing injury, if fallout were allowed to remain in direct contact with the skin, or if the liquid were taken into the body.

Fallout can be washed from the skin and from any foods or containers. Ordinary clothing would prevent most beta radiation from reaching the skin. A person could remove it by simply removing the clothing that was

(Continued on Next Page)

(Reprinted from *The Alabama Sentinel*, published by the Civil Defense Department, State of Alabama.)

(Continued from Page 967)

contaminated and washing the exposed skin areas.

A more dangerous form of radiation present in fallout are the gamma rays. These highly penetrating rays, resembling X-rays, will go through any protective clothing and pass through the body, leaving a trail of damaged cells where they have passed. If enough of these rays pass through the body and enough cells are killed, radiation sickness can result, and even death, if the dosage is sufficiently high. Exposure to a gamma radiation dose of 600 roentgens over a period of a few days would kill most persons.

There are only three ways to protect against gamma radiation—time, distance and shielding mass.

Many ways have been offered to the people of our State and Nation to provide an effective Civil Defense, but it leaves the final choice of preparing an adequate Civil Defense program up to those who have the responsibility on their shoulders of directing our local governmental forces. They say, in essence, you can have Civil Defense, or you cannot have it. You are the one to choose.

I personally feel that as long as this system remains, we will never have the effective Civil Defense program that we need to protect our people in this country. There is so much procrastination in our program that we cannot determine just when we might accomplish the maximum. We who are responsible for the Civil Defense program fail sometimes to understand our audience and where they are, in their concept of Civil Defense.

Too often, maybe, attempts have been made to teach people to build shelters, rather than first carrying out an educational program to increase understanding of the nature of the threat, that you can survive. The need for emergency preparedness and to bring information on the various steps in preparedness for survival and living in the nuclear age represents essentials within the scope of Civil Defense education.

Let's learn what Civil Defense means. It could represent the controlling influence between life and death for all of us!

HOW TO ELIMINATE CONFUSION

Were each drug prescribed a simple, chemically pure substance, one would not be so concerned. However, even the potency of natural products may vary from batch to batch, particularly in the case of the most active ingredients. Consider the great variety of preparations of digitalis, strophanthus, belladonna and other similar substances. Consider also the variety of substances derived from the thyroid gland and other glandular products. In such instances, the simple statement of a generic name does not begin to convey to the user or the prescriber a real picture of the quality of the product. Pharmaceutical manufacturers have offered to the American consumer a variety of preparations from which to choose; the manufacturer, by giving his product a name exclusively his own, identifies that product to the prescriber and the user, and eliminates the possibility of confusion.—Morris Fishbein, M. D., in *Postgraduate Medicine*, (39: 205), February 1966.

MEDICAL JOURNALISM AWARD

The American Medical Association has announced its third annual $5,000 medical journalism awards program "to recognize journalism that contributes to a better public understanding of medicine and health in the United States."

Awards of $1,000 each will be presented for outstanding reporting on health and medicine in five categories—newspapers, magazines, radio, television, and in newspaper and broadcast editorial writing, said F. J. L. Blasingame, M. D., executive vice president of the AMA.

The awards are intended for recognition of outstanding reporting of the scientific and clinical aspects of medicine, Dr. Blasingame said. Awards will be presented in 1967, based on work published or broadcast during the calendar year of 1966.

Entries will be judged on a basis of accuracy, significance, quality, public interest, and impact. Entries will be judged by the 1966 AMA Medical Journalism Awards Committee, which will include outstanding members of the publishing industry, radio and television industry, and the medical profession, he said.

Entries may be sent to the 1966 Medical Journalism Awards Committee, American Medical Association, 535 N. Dearborn St., Chicago, Ill. Deadline is Feb. 1, 1967, although entries may be submitted at any time prior to that date.

Newspaper and magazine articles should be submitted in triplicate, validating date of publication and showing the material as it was presented to the public. Entries for radio or television should consist of three copies of the complete script and a 200-word summary of the script, together with film or kinescope of television entries and audio tape or transcription of radio entries. Entrants may submit as many entries as they wish.

Each entry should be accompanied by a statement listing title of entry, writer or producer, publication in which the article appeared or station or network over which program was broadcast, date entry was published or broadcast, category for which entry is submitted, name, address and title of person submitting entry. Radio and television films, tapes or kinescopes will be returned if requested.

Categories of competition are:

1—NEWSPAPERS: For a distinguished example of a news or feature story or series in a United States newspaper of general circulation published daily, Sunday, or at least once a week.

2—MAGAZINES: For a distinguished example of an article or series in a United States magazine of general circulation published weekly, monthly, quarterly, or at other regular intervals.

3—EDITORIALS: For a distinguished example of editorial writing in a United States newspaper of general circulation published daily, Sunday, or at least once a week; or, for a distinguished example of editorial writing broadcast on a radio or television station.

4—RADIO: For a distinguished example of reporting on medicine or health on a United States radio station or network.

5—TELEVISION: For a distinguished example of reporting on medicine or health on a United States television station or network.

The awards will **not** be given for work, however excellent, that involves primarily the relaying of medical knowledge to the medical profession and to allied professions. Members of the medical profession, medical associations, and their employees are not eligible to submit entries.

PFIZER LABORATORIES ANNUAL MEDICAL SCHOLARSHIP ANNOUNCED

The Medical Department of Pfizer Laboratories, Division of Chas. Pfizer & Co., Inc., announced that it will make available 90 medical student scholarships for the 1966-1967 academic school year.

The scholarship program provides each of the 90 medical schools in the United States with a $1,000.00 scholarship. These scholarships are administered solely by the dean of each medical school, or by a committee established by him.

Selection of the recipient of the scholarship may be on the basis of scholastic record, financial need, or other criteria determined by the individual medical school. The scholarships are designed primarily to apply toward academic and subsistence expenses of one student in each of the medical schools in the United States.

Since their inception in 1962, the Pfizer scholarships have been accepted in each of the medical schools in the United States. In addition to this scholarship, Pfizer has also provided the American Medical Association's Educational and Research Foundation with $350,000 in the past four years for the Foundation's student loan guarantee program.

MEDICAL ECONOMICS AWARD

A 10-day expenses-paid luxury vacation for two at an exclusive resort in the Bahamas awaits the doctor who wins the top 1966 MEDICAL ECONOMICS Award for "the best original article by a physician." Two runners-up will receive cash Awards of $500 each.

Since 1956, MEDICAL ECONOMICS has annually encouraged physicians to share their experiences with their colleagues through the pages of the magazine. This is the second year that a top Award other than cash has been offered in addition to regular payment for accepted manuscripts. The 1965 winner was Dr. Michael J. Moore, a Virginia internist; he and Mrs. Moore were guests of the magazine at the Half Moon Hotel, Jamaica, in the West Indies.

This year's winner will receive a round-trip jet flight to the Rock Sound Club, set in a luxuriant plantation on Eleuthera, an off-the-beaten-track island about 250 miles east of the Florida Keys.

All entries from doctors postmarked by August 31 will be considered. Manuscripts or requests for more information should be addressed to the Awards Editor, MEDICAL ECONOMICS, Oradell, N. J. 07649.

ANNUAL OTOLARYNGOLOGIC ASSEMBLY

October 1 through 7, 1966

THE ANNUAL OTOLARYNGOLOGIC ASSEMBLY OF 1966 will be held October 1 through 7, 1966, in the new Illinois Eye and Ear Infirmary at the Medical Center, Chicago. The Department of Otolaryngology of the College of Medicine of the University of Illinois offers a condensed postgraduate basic and clinical program for practicing otolaryngologists under the direction of Doctor Emanuel M. Skolnik. It is designed to bring to specialists current information in medical and surgical otorhinolaryngology.

Interested physicians should direct communications to the mailing address:

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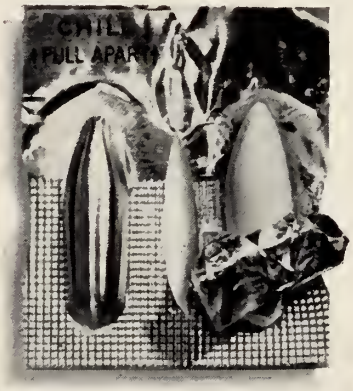
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Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

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The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—The Johnson administration wants to prohibit manufacturers from mailing physicians free prescription drug samples except when specifically requested. The administration also has proposed that door-to-door distribution of samples of over-the-counter drugs also would be banned.

The proposals are included in new drug legislation that would expand the authority and responsibilities of the Food and Drug Administration in policing drugs.

The legislation would have Congress find that:

"(1) the mass of unsolicited samples of prescription drugs supplied to licensed practitioners by manufacturers and distributors through the mails and otherwise has led to large-scale discarding and other disposal of unwanted samples which are finding their way into the hands of persons who scavenge and repack such drugs and sell them to pharmacists for dispensing on prescription in the same manner as regular stock of drugs;

(2) children have obtained carelessly discarded samples;

(3) the dispensing or sale of a prescription drug sample to a patient for a fee without identification of the drug as a sample is a deceptive practice; and

(4) the unsolicited distribution of non-prescription sample drugs directly to householders lacks minimum safeguards which would be involved in the sale of the drug in a pharmacy or other place of business.

Labels would have to read: "SAMPLE DRUG. FEDERAL LAW PROHIBITS ANY CHARGE OR FEE FOR THIS DRUG."

Under the legislation, the FDA would be authorized to require records and reports of adverse reactions and efficacy on all drugs now being marketed. Dr. James L. Goddard, Food and Drug Administration commissioner, already had ordered a review of drugs cleared before 1962.

Another provision of the legislation would "require certification of all drugs whose potency and purity can mean life or death to a patient," thus extending the law which now applies to insulin and antibiotics.

The Pharmaceutical Manufacturers Association expressed doubt that the FDA could carry out such an additional responsibility. PMA President C. Joseph Stetler said it seems "unwise to propose new areas of responsibility for an agency which has not yet proven its ability to administer" its present programs. Stetler added:

"The industry has said before that no amount of labeling can protect an individual who refuses to protect himself by ignoring his doctor's orders or the directions on the label of his medicine. Even when manufacturer and patient do everything right, an adverse reaction still is possible and medical science probably never will find a way to make it otherwise.

"There is no such thing as 'miracle legislation' which automatically produces a drug utopia."

In a speech highly critical of the ethical drug industry at the annual meeting of the PMA, Goddard talked of irresponsibility. He said "too many drug manufacturers may well have obscured the prime mission of their industry: to help people get well." He said he had been shocked by the quality of some of the data on new drugs submitted to the FDA. There also "is the problem of dishonesty in

the investigational drug stage," he said.

Goddard further charged that some drug advertisements "have trumpeted results of favorable research and have not mentioned unfavorable research; they have puffed up what was insignificant clinical evidence; they have substituted emotional appeals for scientific ones."

Stetler said after the speech that he and his colleagues feared the talk "might, unfortunately, be interpreted as an indictment of the entire drug industry, because of its overemphasis on isolated instances, without acknowledging the integrity and responsibility which our industry has consistently demonstrated."

"It is an unassailable fact," Stetler said, "that the scientific attainments and standards of performance of the American prescription drug industry have provided an immeasurable benefit to the improvement of health and the prolongation of life."

* * *

Officials estimate that the hospitalization part of medicare will cost about $2.3 billion in the first year of the program which starts July 1.

Benefit payments under Plan B. the medical part of medicare, are estimated at $765 million for the first year. Premium collections—$3 per person per month—are estimated at $550 million, which will be matched by the federal government.

Persons 65 years or older have until May 31 to sign up for Plan B. The original deadline for signing up was March 31. On that date, 1.3 million of the 19.1 million persons 65 or older had not indicated whether they wanted Plan B coverage. About 16.8 million, or 88 per cent, had signed up and one million, or about five per cent, had said they did not want the coverage.

President Johnson signed the deadline extension into law at a ceremony at a federally-financed apartment project for the elderly at San Antonio, Tex., while he was spending the Easter holidays at his Texas ranch.

Rep. Durward Hall, M. D., (R.. Mo.) reported that a poll of his constituents showed them overwhelming against extending medicare to persons of all ages. Of 13,760 persons replying to a questionnaire, 86.3 per cent said "no" to the question: "Do you favor increasing social security taxes to finance a compulsory medical program for the entire population?" "Yes" answers totaled 11.2 per cent and 2.5 per cent didn't answer the question.

* * *

The federal government received segregation complaints against about 320 hospitals after a special policing agency was set up in the Department of Health, Education and Welfare.

Dr. Philip R. Lee, HEW Assistant Secretary for Health and Scientific Affairs, said that about 100 of the complaints were settled by negotiation with the hospitals.

"This leaves us with pending complaints against approximately 220 facilities, most of which have been investigated and found to be out of compliance and therefore ineligible for new federal funds," he said.

* * *

President Johnson has ordered that steps be taken to give rehabilitation aid to more of the disabled persons on public welfare.

In a letter to HEW Secretary John Gardner, President Johnson noted that the federal budget for fiscal 1967 would provide for vocational rehabilitation training for 215,000 handicapped persons, a 25 per cent increase over the present year, and added:

"As we plan for the larger program I believe we should do better than we have in rehabilitating persons who are now on our public welfare rolls. In the last several years, although the absolute numbers have increased, the proportion of welface recipients receiving training has declined from 15 per cent to 13 per cent. I think this trend should be reversed . . .

"I would like you to review the possibilities in this area and report to me with recommendations for federal and state action by June 1."

LOS ANGELES SCENE FOR 1966 SAMA CONVENTION

Leaders of the American medical community and delegates from more than 75 medical schools will gather in Los Angeles May 12-15, 1966 for the 16th Annual Meeting of the 60,000 member Student American Medical Association.

SAMA President James P. Moss, University of Louisville senior, will preside over the four-day session expected to attract 1,500 registrants to convention headquarters in the Statler-Hilton hotel.

Policy decisions for the Association, largest medical student group in the world, will come from the House of Delegates under the leadership of Vice President Gerald King (South Carolina) and Blair Behringer (Missouri), national Treasurer.

In addition to the scientific program the meeting will feature an 80-booth Professional Exhibit as well as numerous social events.

Outstanding physicians and experts in sexual counseling will appear on the May 13th Symposium "Sexual Counseling and the Physician." The panelists and their papers are: "What Doctors Know About Sex," David M. Reed, Ph. D., Tulane University School of Medicine; "Talking with Patients About Problems of Sex," Richard H. Klemer, Ph. D., Associate Professor of Family Relations, U. of Washington School of Medicine, Seattle; "Dealing with Teenagers and Premarital Sex Problems," Mary S. Calderone, M. D., Executive Director, Sex Information and Education Council of the United States (SIECUS); "Understanding Sex Deviations," Edward M. Litin, M. D., Chairman, Department of Psychiatry, The Mayo Clinic and "The Sexually Incompatible Marriage Partners," Titus Belleville, M. D., University Hospital, Minneapolis. The symposium is presented with the cooperation of Lederle Laboratories.

"Mycoplasma and L-Forms of Bacteria" is the title of the Upjohn Symposium to be moderated by Monroe Davis Eaton, M. D., Harvard University Medical School professor who did pioneer work in this area more than 20 years ago. The program is set for May 14th.

Panelists on Dr. Eaton's presentation include: Leonard Hayflick, Ph. D., The Wistar Institute of Anatomy and Biology, Philadelphia, "The Biology of Mycoplasmas"; Maurice A. Mufson, M. D., Chief Resident Physician, U. of Illinois Division of Medicine, Cook County Hospital, Chicago, "Relation of Mycoplasma to Human Respiratory Tract Diseases" and Lucien B. Guze, M. D., Assistant Professor of Medicine, UCLA, "Observations of the Possible Role Protoplasts in Disease."

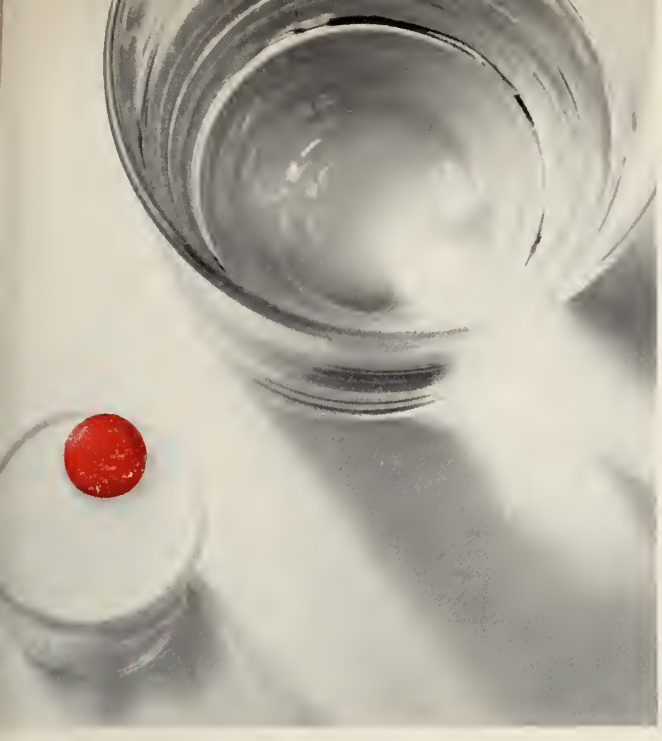
The Annual Awards Banquet on Thursday evening, May 12th will feature the Presidential Address to be given by the eminent surgeon Jonathan E. Rhoads, M. D., the John Rhea Barton Professor of Surgery at the University of Pennsylvania School of Medicine.

The 1966 meeting will unveil the annual "Doctor and the Law" luncheon designed to broaden the understanding of medical practice and its relationship to law. The luncheon speaker will be the noted forensic pathologist and editor of TRAUMA, Doctor Don Harper Mills of Los Angeles. The program is made possible by a grant from Wyeth Laboratories who also provide the national newsletter "The Doctor and the Law" as an insert in SAMA's official publication The New Physician.

Other luncheons will present President Amos N. Johnson, M. D., of the American Academy of General Practice as the speaker at a Friday noon session sponsored by the Academy and AMA President-Elect Charles Hudson, M. D., Cleveland, the guest speaker at the Saturday noon gathering sponsored by the American Medical Association.

Hollywood personality and political aspirant Ronald Reagan is listed as the guest speaker for the May 13th breakfast program sponsored by the American Medical Political Action Committee.

The Presidents Ball honoring the current officers of the Association is the closing social event of the meeting on Saturday night.





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Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg of demethylchlortetracycline HCl.

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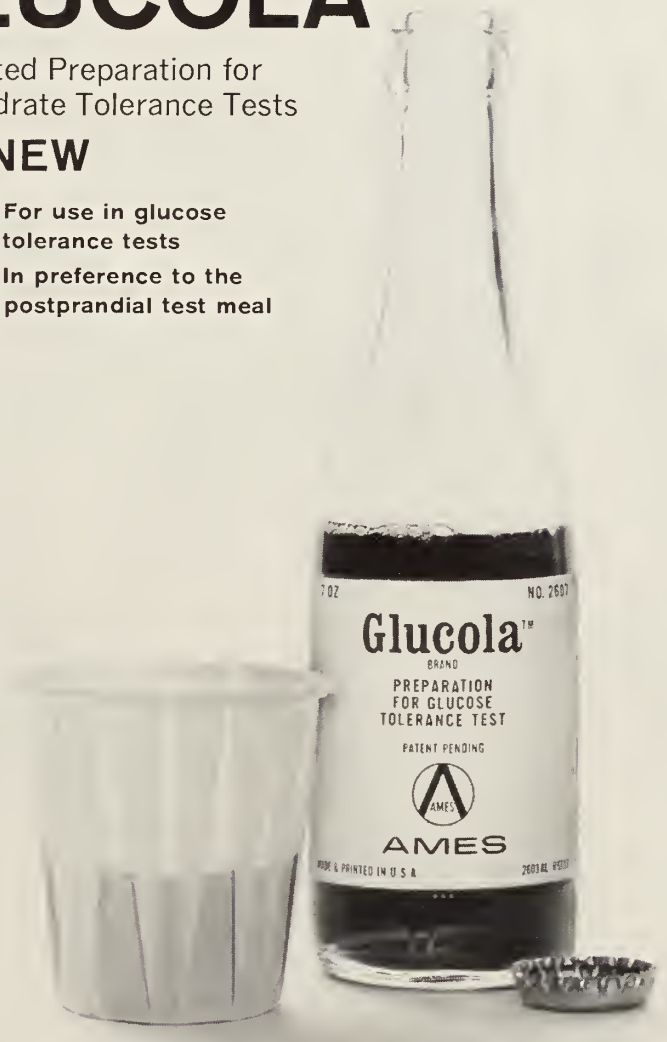
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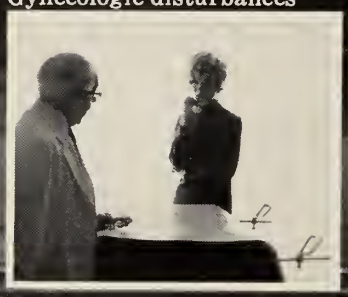
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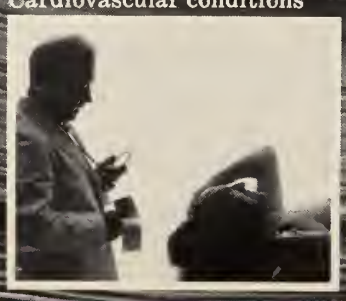
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Reese, H. H.: *Wisconsin*

M. J. 15:344, 1939.
chigan M. Soc. 38:317,

Horan, T. H.: *Ann. Int.*

Putnam, T. J.: *Arch. Neu-* 1053, 1939.
al Sc. 85:986, 1939.
el, D. L., Jr., and Arnold, *onth.* 66:522, 1939.

l Osgood, R.: *J.A.M.A.*

ennett, C. L.: *Psychiat.* 0.
Washington Bull. 3:16.

oldstein, H. H.: *Am. J.* 1940.
kson, V.: *Ann. Int. Med.*

d. M.A.J. 43:157, 1940.

Tulane Med. Fac. 1:2,

. Times 69:461, 1941.
d Shallenberger, D. W.: :383, 1941.
d. Bull. Veterans Admin.

cet 61:178, 1941.

Rec. 155:105, 1942.
m. J. Psychiat. 98:515,

M.A. 120:449, 1942.
J. Psychiat. 99:231,

mes 70:244, 1942.
ner, C.: *J. Nerv. &*
J.A.M.A.

Queries & Minor Notes: *J.A.M.A.* 124:200, 1944.
Gingrass, R. P.: *Wisconsin M. J.* 43:934, 1944.
Vallotton, C. F.: *Virginia M. Month.* 71:159, 1944.

Butter, A. J. M.: *J. Neurol. Neurosurg. & Psychiat.* 8:49, 1945.
Lennox, W. G.: *M. Clin. North America* 29:1114, 1945.

Bashinsky, B.: *J.M.A. Georgia* 35:228, 1946.

Twitchell-Allen, D.: *Arch. Neurol. & Psychiat.* 57:617, 1947.
Keith, H. M.: *Am. J. Dis. Child.* 74:140, 1947.
Wigton, H. A.: *Nebraska M. J.* 32:272, 1947.
Hoefer, P. F. A.; Hoff, H. H., and Pluvinage, R. I. L.: *Tr. Am. Neurol. A.* 72:185, 1947.

Fabing, H. D., and Hawkins, J. R.: *Ohio M. J.* 44:257, 1948.
Thorne, F. C.: *Am. J. Psychiat.* 104:570, 1948.
DeJong, R. N.: *Am. Practitioner* 3:233, 1948.
Tudor, R. B.: *J. Lancet* 68:391, 1948.

Yannet, H.; Deamer, W. C., and Barba, P. S.: *Pediatrics* 4:677, 1949.
Silverstein, A.: *Am. Practitioner* 3:344, 1949.
Lennox, M. A.: *Am. J. Dis. Child.* 78:868, 1949.

Roseman, E.: *Postgrad. Med.* 8:419, 1950.
Ruskin, D. B.: *Am. J. Psychiat.* 107:415, 1950.
Chaiken, B. H.; Goldberg, B. I., and Segal, J. P.: *New England J. Med.* 242:897, 1950.

Forster, F. M.: *J.A.M.A.* 145:211, 1951.
Bakwin, R. M., and Bakwin, H.: *J. Pediat.* 39:776, 1951.
Ransone, J. T.: *Virginia M. Month.* 78:303, 1951.

Sokolova, E. I.: *Zhur. nevropat. i psikhiat.* 53:385, 1953.

Davidson, D. T., Jr., and Lombroso, C.: *New England J. Med.* 251:853, 897, 1954.
Hopkins, S. J.: *Chemist & Druggist* 161:628, 1954.
Hernandez, R., L.: *J. Am. M. Women's A.* 9:188, 1954.

Drew, A. L.: *Postgrad. Med.* 18:327, 1955.
Williams, E. Y., and Carmichael, C. P.: *J. Nat. M. A.* 47:162, 1955.
Millichap, J. G.; Lombroso, C. P., and Lennox, W. G.: *Pediatrics* 15:705, 1955.

Murphy, J. T., and Schwab, R. S.: *J.A.M.A.* 160:385, 1956.
Livingston, S.: *Postgrad. Med.* 20:584, 1956.
Gruber, C. M., Jr.; Mosier, J. M.; Grant, P., and Glen, R.: *Neurology* 6:640, 1956.
Levy, L., and Shanbrom, E.: *Arch. Int. Med.* 97:599, 1956.
Utterback, R. A.: *Am. Pract. & Digest Treat.* 7:763, 1956.
Zimmerman, F. T.: *New York J. Med.* 56:2537, 1956.

Berry, R. G., in Spiegel, E. A. (ed.): Progress in Neurology and Psychiatry, New York, Grune & Stratton, 1957, vol. 12, pp. 199-211.
Daly, D. D.: *Proc. Staff Meet. Mayo Clin.* 32:257, 1957.
French, E. G.: *Am. J. Psychiat.* 113:629, 1957.
Maltby, G. L.: *J. Maine M. A.* 48:257, 1957.

Rupp, C., Jr.: *J.A.M.A.* 166:1967, 1958.
Peterman, M. G.: *Minnesota Med.* 41:196, 1958.
Livingston, S.: *J. Lancet* 78:182, 1958.
Carter, C. H.: *Arch. Neurol. & Psychiat.* 79:136, 1958.
Keith, H. M.: *J. Lancet* 78:461, 1958.
Farmer, T. W.: *South. M. J.* 51:173, 1958.
Hammill, L. F.: *J. Chronic Dis.* 8:448, 1958.

Yahr, M. D., and Merritt *Neurol.* 1:76, 1959.
Thomas, M. H.: *J.A.M.A.*
Peterman, M. G., and T *Times* 87:1044, 1959.
Bray, P. F.: *Pediatrics* 2
Mulder, D. W.; Daly, D. and Yoss, R. E.: *Postgra* 1959.
Forster, F. M.: *Wisconsi* 1959.
Robertson, E. G.: *Postgr* 1959.

Schwade, E. D.: *Geriatr*
Schade, G. H., and Gof 25:151, 1960.
Forster, F. M.: *Postgrad* 1960.
Livingston, S.: *J.A.M.A.*
Friedlander, W. J.: *Am.* 1960.

Kane, C. A.: *Boston Med* 1961.
Holowach, J.; Renda, Y. *J. Pediat.* 59:339, 1961
Baker, A. B.: *J. Lancet* 8
Roseman, E.: *Neurology*

Gruber, C. M., Jr.; Brocl M.: *Clin. Pharmacol. &* Walker, A. E.: *World Neu*

Pauli, L. L.: *Maryland M.*
Livingston, S.: *Clin. Ped*
Forster, F. M.: *M. Clin.* 47:1579, 1963.
Scholl, M. L.: *New Engla* 269:1304, 1963.

Kutt, H.; Winters, W.; K McDowell, F.: *Arch. Ne* Currier, R. D.: *GP* 30:12
Chao, D.; Sexton, J. A., *J. Pediat.* 64:499, 196

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(1) Portnoy, J.: Brewer, J. and Harris, A.: PUBLIC HEALTH REPORTS, *77:*645-652, August 1962. (2) Joseph, J. M. and Warner, G. S.: A WORKSHOP MANUAL, Md. State Dept. Health, Bureau of Lab., Balto., Md., September 1962. (3) Wollenweber, H. L.: OFF. PATH., *2*, February 5, 1963. (4) Portnoy, J.: MILIT. MED., *128:*414-417, May 1963. (5) Portnoy J.: THE AMER. JOUR. OF CLIN. PATH., *40:*473-479, November 1963. (6) Buck, A. A. and Mayer, H.: THE AMER. JOUR. OF HYG., *80:*85-90, July 1964. (7) Brown, W. J.: Donohue, J. F. and Price, E. V.: PUBLIC HEALTH REPORTS, *79:*496-500, June 1964. (8) Clayton, J. L.; Lindhardt, E. M. and Fraser, R. S.: PUBLIC HEALTH LAI *22:*206-207, November 1964. (9) Lucatorto, F. M.; Katz, B. D. and Toto, P. D.: THE J.A.D.A., *69:*697-699, December 1964. (10) Portnoy, J.: PUBLIC HEALTH LAB., *23:*43, March 1965. (11) Reed, E. L.: PUBLIC HEALTH LAB., *23:*96-103, May 1965.

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President's Page



Dr. J. O. Finney

The members of the Mobile County Medical Society and their wives deserve a special expression of appreciation for display of outstanding hospitality throughout the entire 105th Annual Session of the Medical Association of the State of Alabama. I would like to add a word of thanks in addition to the Resolution of Appreciation presented by Dr. Harmon Stokes at the conclusion of the meeting.

All arrangements and commitments were accomplished with delightful quiet and smoothness. The coordination throughout evidenced superb advance planning by our Executive Secretary and his staff from our central office.

The scientific presentations were of high quality and wide interest. For this our accolade goes to the Program Committee and the speakers selected.

The Scientific Exhibits were interesting and informative. I think we should encourage expansion of this facet, when available space permits.

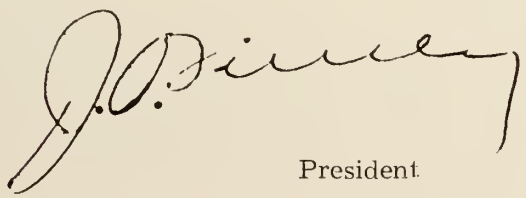
One of the real highlights of the meeting was the masterful presentation of Dr. Ira Myers on Progress and Continuing Problems of our Health Department. The visual aids employed were strikingly impressive.

The Saturday morning session was quite a ventilatory exercise for the Delegates, Councillors and Officers. Dr. James Donald, endowed with a Churchillian corpus, presided with adroitness and acumen. His timely explanations of issues being debated were instructive and very helpful.

The smoke of battle has cleared and the votes have written the record. Those unable to attend the meeting should be informed that every issue, regardless of the area concerned, was settled by an *overwhelming* majority and not by the "skin of the teeth." This should encourage us to abandon division in our ranks and set a solid front in motion to achieve our declared purposes.

The 105th year of our organization has passed. The position of our Association as the State Board of Health demands that in our 106th year we continue to present to the public accomplishments consistent with the trust implied. In this task we must not fail; we are the only state in which the Board of Health is so constituted. We cannot continue to operate effectively in the discharge of our duties and responsibilities in this area unless our Association remains a unified body of superior strength and high purpose.

We missed those of you unable to attend the Annual Session in Mobile, and you missed a stimulating meeting. Plan now to be present for the pyrotechnics next April.



President

The Woman's Auxiliary

Alabama Physicians, thank you, not only was the Convention in Mobile informative, but delightful. Wives, if you didn't attend the 42nd Annual Auxiliary Meeting, you missed our meaningful work, and our fun too. As Montgomery County reported, "To rest is to rust." Because of a request from WASAMA's representative, Mrs. John Roe Denton, the hat was passed, and we raised money to send an extra representative (from their group) to their convention.

Mrs. Belle Chenault, Decatur, Past President of Alabama Medical Auxiliary, 1954-1955 and at present a director and chairman of Nomination Committee for National was awarded a State Honorary Membership, and a standing ovation by members. Our thanks for Mrs. John Chenault's outstanding work in Medical Auxiliary, locally and nationally.

Mrs. W. G. Thuss, Sr. who is President to Southern Medical Auxiliary was honored at our Thursday luncheon. A most interesting and informative speech was given to us, drawing a parallel on foreign medical procedures and our accustomed American medical care.

Friday, the luncheon honored Mrs. Richard A. Sutter, President of our National Auxiliary. The following is a resumé taken from her talk. "Medicare and other federal programs, increasing our individual dependence upon an ever more powerful centralized government, might be said to have played a role in causing the Auxiliary to the American Medical Association to evaluate its effectiveness in "assisting the AMA in its program for the advancement of medicine and the public health."

MD'S WIFE is sent to all of our nearly 90,000 dues-paying Auxiliary members, six issues per year, and provides direct communication to many members, and to outside organizations. From reactions all over the country MD'S WIFE is projecting a positive picture of meaningful Auxiliary activity, reinforcing the purposes of Auxiliary members and raising the horizon of Auxiliary potential.



Mrs. Ira B. Patton

Historically the Women's Auxiliary has been concerned with Health Education, also referred to as lay or public education. Educated women are seeking activity in only those organizations which challenge their intelligence and abilities. They want to extend themselves into meaningful work, not just the periphery. A recent nation-wide study of health education in the schools, financed by the Bronfman Foundation and conducted with the co-operation and under the supervision of five national organizations, indicates that school systems, with few exceptions, pay little or no attention to health education, even when it is a part of the curriculum. Some of the misconceptions endorsed by 70 per cent of high school seniors in this national survey included: The best source of help for a *persistent* cough or a *persistent* skin inflammation is a pharmacist; for a *painful back injury,* a chiropractor; use of pep pills or sleeping pills does *not* require medical supervision; legislation guarantees the *reliability* of any advertised medicine;

fluoridation is done to *purify* water for drinking purposes.

The Bronfman study also revealed that senior students know very little about Community Health. One third of those surveyed believed that voluntary health agencies, such as TB and Cancer Societies, had the power to enforce necessary Community Health regulations. One third also believed that a full-time public health department provides complete medical diagnosis and treatment for any citizen.

Anyone who observed the recent televised Health Tests knows the pitiful level of health information held by the adult public. Among those who participated in specific groups taking the tests, one third did not know the normal temperature reading on a clinical thermometer. Those who took the tests were literate people, whom we obviously are not reaching. How about the illiterate? Parents with inadequate understanding of health perpetuate the cycle of fear and superstition through their children, unless the schools do a better job in teaching health. Adult education may well be the only salvation for the poverty and welfare dilemma we face, helping people to help themselves.

Let us not underestimate our social purpose in aiding understanding among physicians' families. In this year of transition, this time of divided opinions, our Auxiliaries have a most important role to play in promoting good fellowship and friendly relations within the profession.

Mrs. Ira B. Patton

President

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Editorial COMMENT

DECISION IS DUE ON INCREASE IN AMA DUES

The AMA House of Delegates, meeting this month in Chicago, will come to grips with the Association's precarious financial situation in search of an answer to the question: Should AMA annual dues be increased from $45 to $70 per year?

Executive Vice President F. J. L. Blasingame made a strong case for the dues increase at the 1965 Clinical Convention last November. He stated the fact simply: AMA must either have additional operating revenues, deplete further its reserves, or drastically curtail some of its activities.

Undoubtedly there will be many present ready to argue for or against each of the alternatives. At this writing it is not an established fact that the dues will be boosted.

Some of AMA's operating costs cannot be controlled and it is folly to suggest that a paring of the budget all along the line is the solution. For instance, a continuing spiral in the cost of everything AMA buys has reduced the purchasing power of the dollar about one half. Taxes on AMA properties have increased 200 per cent since 1959. Social Security taxes amounted to $160,000 in 1960; this year they will drain $276,000 from the coffers.

Dues account for less than 28 per cent of AMA income. More than 60 per cent is derived from such sources as subscriptions to its several publications, sale of advertising, rental of exhibit space and investments.

Alabama physicians with strong opinions on the question of a dues increase of more than 50 per cent would serve their interests by making their views known to one of the delegates (listed in the front of The Journal). The final decision will be made in democratic fashion with the votes of the majority prevailing.

A REPORT WHICH REFLECTS A YEAR OF PROGRESS

The official report of outgoing President James G. Donald of Mobile—an 18-page double-spaced document—will be published in its entirety in the Annual Transactions of the Medical Association of the State of Alabama, now being readied by the printers. A copy will be distributed through that medium to all members. It is recommended reading and well worth the time of every Alabama physician needed to digest its contents.

As The Journal has stated previously, the office of President has become the most demanding in organized Medicine in Alabama. Perhaps it doesn't carry the fearsome long-range responsibilities of the Chairman of the Board of Censors, or even of the members of that body, but it does require countless hours

(Continued on Page 989)

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in chewable tablets

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When combination antibiotic therapy is indicated...



CONSIDER: an exceptionally high cure rate in susceptible infections

The rationale: When combined, Erythrocin and the trisulfapyrimidines (triple sulfas) are indicated in infections that are more susceptible to the combination than to either agent alone. Such conditions are usually found in urinary, lower respiratory tract and chronic ear conditions.

The results: Clinical studies involving 142 young patients showed *an overall cure rate of 96.5%*. Side effects were experienced by only four of the patients.

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ERYTHROCIN®-SULFAS
Brief Summary

Indications: Use Erythrocin-Sulfas in infections more susceptible to the combination than to either agent alone. These are usually found in urinary, lower respiratory tract, and chronic ear infections.

Contraindications: Known sensitivity to erythromycin or sulfonamides. Because of the possibility of kernicterus with sulfonamides, do not use in pregnancy at term, premature or new born infants.

Warnings: As with other forms of sulfonamide therapy, carefully evaluate patients with liver or kidney damage, urinary obstruction, or blood dyscrasia. Deaths have been reported from hypersensitivity reactions and blood dyscrasias following use of sulfonamides. Perform blood counts and liver and kidney function tests if used repeatedly at close intervals or for long periods.

Precautions: Use sulfonamides with caution in patients with a history of allergy. Assure adequate fluid intake to prevent crystalluria and institute alkali therapy if indicated.

Adverse Reactions: Sulfonamide therapy may be associated with headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Side effects due to erythromycin are infrequent, but occasional abdominal discomfort, nausea, or vomiting, urticaria and other skin rashes may occur.

If a reaction or overgrowth of nonsusceptible organisms occurs, withdraw the drug.

Supplied: The Granules for Oral Suspension come in bottles of 60 ml. and 150 ml. The Chewable tablets are in bottles of 50. Each 5-ml. teaspoonful of reconstituted Granules or each Chewable tablet provides erythromycin ethyl succinate equivalent to 125 mg. of erythromycin activity and 167 mg. each of sulfadiazine, sulfamerazine and sulfamethazine. 603303

ABBOTT

A YEAR OF PROGRESS

(Continued from Page 986)

of planning, time expended in execution of plans, and hours of attendance at meetings both large and small at which Medicine has a stake.

It was with a note of pride that Dr. Donald presented his report to Counsellors and Delegates to the Annual Session in Mobile on April 21. He cited fact and figure wherein his administration had served well the cause of the physicians of Alabama. In almost every sphere of the Association's interest he could report "mission accomplished."

A first impression of Dr. Donald is that he is a mild-mannered individual of the highest moral caliber. This proved to be true but he also showed a tough fiber and an agile mind which served him admirably in the gut-cutting fights which erupted on all sides during his tenure.

Dr. Donald set a man-killing pace in the Year of Medicare with its attendant difficulties. He foresook loved ones and his surgical practice to render yeoman service to his profession. For this he merits the gratitude of the membership, which he currently is receiving in large measure.

WHAT'S THE DIFFERENCE?

We hear a lot these days about "intermediaries" and "carriers" as those nouns are applied in Public Law 89-97. What is the difference? Well, it seems that "intermediary" is a public or private organization which serves as the government's contracted agent to reimburse for expenses covered by the hospital part of Title XVIII, Part A. A "carrier" will make payments for the charges of physicians and other medical services under Part B.

The man whose great-grandfather built a railroad through the wilderness without asking approval, now has to get a permit to remodel his front porch.—Modern Maturity.

(Continued on Page 992)

When uncontrolled diarrhea brings a call for help



When the diarrhea sufferer has run the gamut
home remedies without success, pleasant-tasti
CREMOMYCIN can answer the call for help. It can
counted on to consolidate fluid stools, soothe int
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detoxify putrefactive materials — usually within
few hours.

CREMOMYCIN combines the bacteriostatic agen
succinylsulfathiazole and neomycin, with the a
sorbent and protective demulcents, kaolin and pe
tin, for comprehensive control of diarrhea.

INDICATIONS: Diarrhea.

CONTRAINDICATIONS: Do not use in intestinal obstruction,
tensive ulceration of bowel, or diverticulosis; in hypersensiti
to sulfonamides or neomycin; in pregnancy at term, in prematu
infants, or during first week of life in the newborn.

WARNINGS: Use only after critical appraisal in patients w
hepatic or renal damage, urinary obstruction, or blood dysc
sias. Fatal hypersensitivity reactions and blood dyscrasias
ported with use of sulfonamides. Consider periodic blood cour
hepatic and renal function tests during intermittent or chro
use.

PRECAUTIONS: Succinylsulfathiazole: Use with caution if the
is history of significant allergies and/or asthma. Continued u
requires supplementary vitamins B_1 and K. *Neomycin:* Watch

your ℞ for Cremomycin can provide relief



rare-like neuromuscular block during anesthesia if neomycin used preoperatively in large doses when renal function is or; watch for overgrowth of nonsusceptible organisms. Con- ler possibility of ototoxicity and nephrotoxicity with prolonged gh dosage.

DE EFFECTS: As with all sulfonamides: Headache, malaise, an- exia, G.I. symptoms, hepatitis, pancreatitis, blood dyscrasias, uropathy, drug fever, rash, conjunctival and scleral injection, techiae, purpura, hematuria, and crystalluria have been noted. duced fecal output of thiamine and decreased synthesis of amin K have been reported. *Neomycin:* Nausea, loose stools.

fore prescribing or administering, read package circular with oduct or available on request.

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here today's theory is tomorrow's therapy

STANDING OVATIONS FOR TWO SERVANTS OF MEDICINE

Twice during the final business meeting of the Annual Session of the Medical Association of the State of Alabama, held in April at Mobile, the Counsellors and Delegates rose to their feet in spontaneous applause for two men whose services to Medicine will always rank high in the annals of this organization.

The first standing ovation was given to Dr. Ira L. Myers, State Health Officer, at the conclusion of his annual report which was dramatically illustrated by multi-colored slides projected on a large screen. A digest of Dr. Myers' report appears in this issue of The Journal. We commend it to our readers as an outstanding example of public service.

The second ovation, easily the most heartwarming moment of the entire Session, came when Medicine's beloved Dr. J. Paul Jones of Camden was awarded a plaque and an album of photographs upon his retirement from the Board of Censors after 15 years service—the last five years as Chairman.

Without benefit of text or notes, Dr. Jones made a brief acceptance speech in which he thanked the Association for the many honors bestowed upon him. It is entirely possible that he had planned to say nothing upon the occasion of the surrender of his authority, preferring to slip quietly into the background and the more leisurely life he has so richly earned.

But he reckoned without knowledge of the enduring love and respect held for him by every member of the Association who has been privileged to know him. His impartiality as a presiding officer, his strong hand of leadership, his calm demeanor when fires of conflict were burning fiercely, his ability to recognize pitfalls and danger signals, his attention to detail without losing focus of the overriding issues had won for him the admiration of his contemporaries everywhere.

It is unbelievable that Dr. Paul will or could ever simply fade into oblivion. It is more likely that he will continue to be around for a long time, offering his sage counsel when it is requested by his successors, and regarding with pride the many fruits of his labors.

THE LADY IS WELCOME

This Journal happily welcomes to its galaxy of authors the lady who has shouldered responsibility for the monthly page devoted to activities of the Woman's Auxiliary. She is Mrs. Ira B. (Darlene) Patton of Oneonta.

The new president of the Auxiliary has a creditable record of service to Medicine through her organization. In addition to her duties as President-elect last year she also served as State Membership Chairman. She was State Treasurer in 1962, as well as President of her County Auxiliary. In 1960-61 she was State Program Chairman.

There is a very distinct place in the structure of this Association for the wives, mothers, daughters and sisters of physicians. They constitute a powerful force for dissemination of information, on the outcome of legislation, and in the betterment of public relations.

To the ladies we say "thanks for everything and God bless you! May we always have the pleasure of your gracious presence, and the benefit of your counsel and assistance in all of our endeavors."



One Signature

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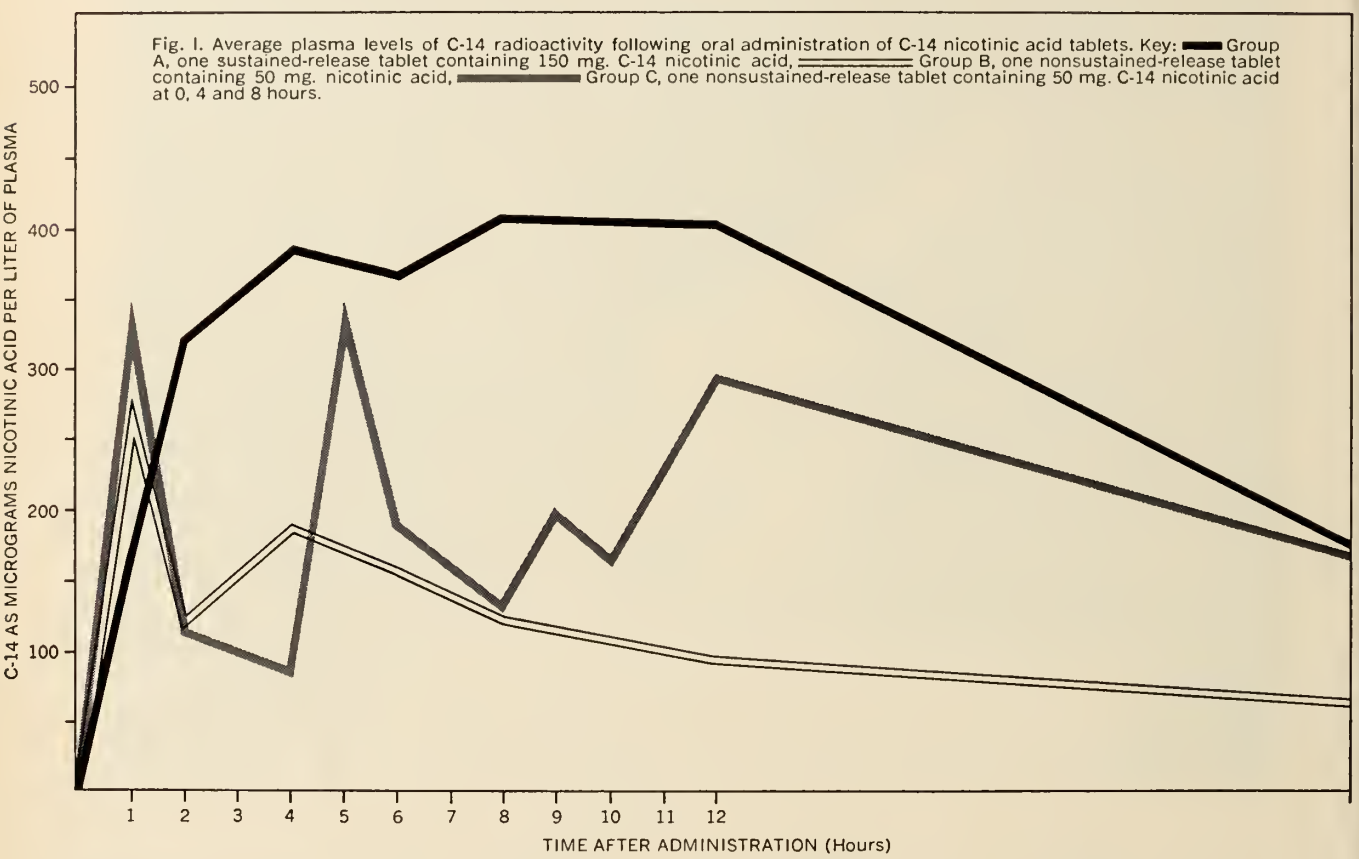
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LIFE & CASUALTY

Sustained circulatory, respirator and cerebral stimulation for th

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

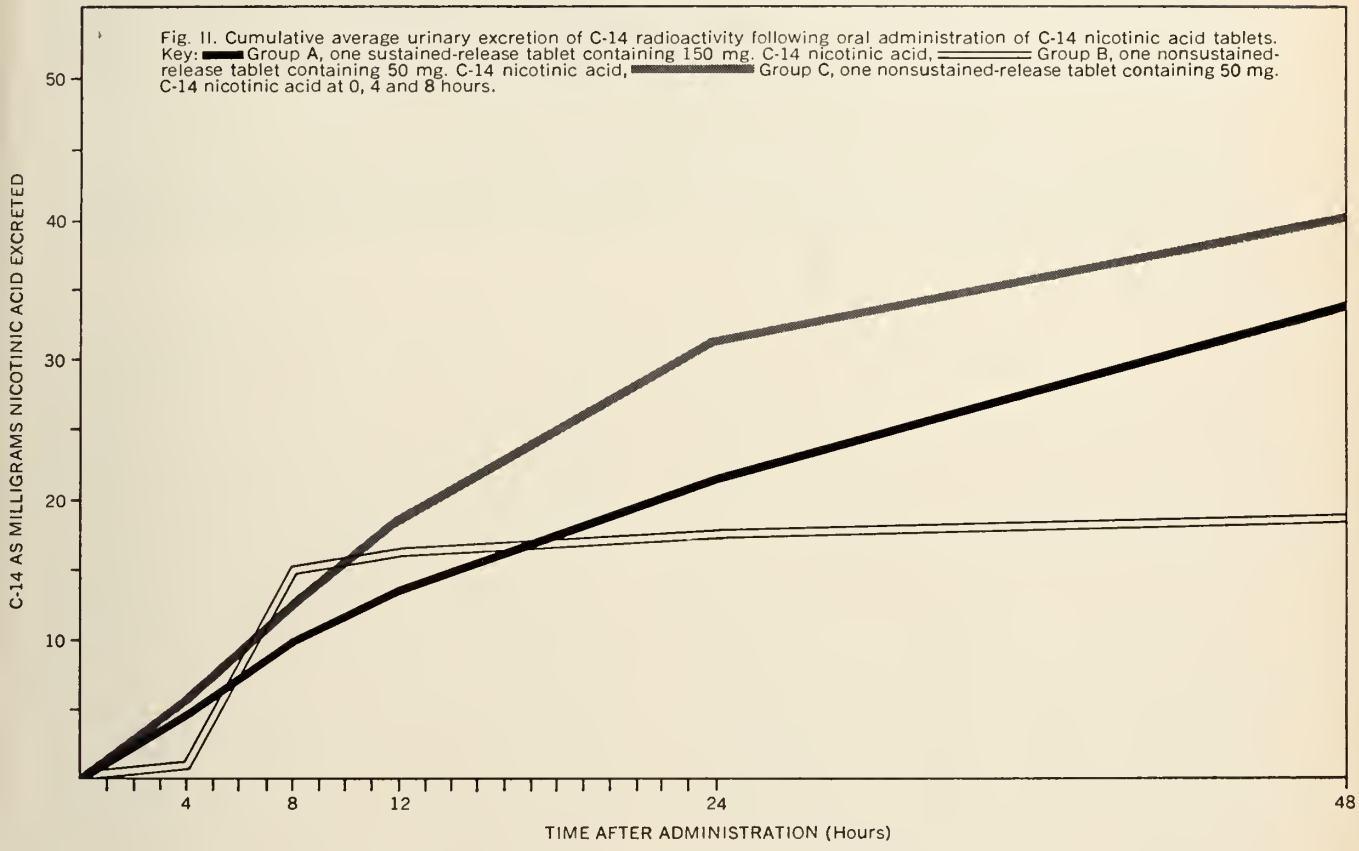
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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TWO NEW MEMBERS ELECTED TO MASA BOARD OF CENSORS

Two new names have been added to the State Board of Censors as the result of elections held on the final day of the Annual Session in Mobile.

They are Dr. Everett Leonard Strandell of Brewton, named to succeed Dr. John Paul Jones of Camden for a five-year term, and Dr. Jasper Dixon Bush, Jr., of Gadsden elected to serve the unexpired term of President J. O. Finney, which would have extended to 1968.

Both are widely known for service to medicine, having been elected to the presidencies of their respective county medical societies and appointed to membership on committees of MASA.



Dr. Bush



Dr. Strandell

J. D. BUSH, JR., M. D.

Born in Decatur, Alabama, in 1909, Dr. Jasper Dixon Bush, Jr., received his medical education at Rush Medical College, Chicago, graduating in 1936.

He returned to Alabama that same year and interned at Hillman Hospital in Birmingham in 1938. The following year he served a residency in pathology at Hillman and then was an instructor at the Medical College of Alabama, first at Tuscaloosa and later when the institution was moved to Birmingham, until 1946.

For the next two years he was associated with Dr. Albert E. Casey at Birmingham Baptist Hospital, moving in 1948 to Gadsden where he has since resided and practiced.

Dr. Bush has served as President of the Etowah County Medical Society and as President of the Alabama Association of Pathologists. For two years he was a member of the Committee on Public Relations. In 1957 he was married to the former Mamie Lowe Posey of Birmingham.

His hobbies are water sports and fishing. He is owner of a cottage on Guntersville Lake just a stone's throw from the cottage of Dr. Finney, whom he succeeded as censor.

EVERETT L. STRANDELL, M. D.

Born in Minnesota in 1912, Dr. Strandell received his AB degree from George Washington University and his MD degree from the University of Minnesota in 1942. Immediately after graduation he enlisted in the Army Air Corps and served for four years at Maxwell Air Force Base, Montgomery.

In 1947 he established practice in Brewton as a general practitioner. Ten years ago he and several other physicians formed a clinic.

Dr. Strandell's abilities were recognized early by other physicians of Escambia County and he soon was elected President of the county medical society. He has served several terms since then as a member of the county Board of Censors.

Among MASA committees on which Dr. Strandell has served are Public Relations, Finance, and Legislation. He was Vice President for the Southwestern District for eight years and a member of the 1964-65 Board of Trustees.

While in graduate school Dr. Strandell married the former Mary Leigh, a native of Virginia. They have no children. He is a member of the Episcopal Church and the Rotary Club of Brewton.

His hobbies are hunting and fishing.



QUESTIONS MOST OFTEN ASKED ON MEDICARE . . .

Since the enactment of P. L. 89-97, Medicare, many physicians, and others have written to the AMA Advisory Committee seeking clarification of benefits and provisions under the law. As the implementation of the program has progressed, many of these questions have been asked of Social Security so that the Advisory Committee may better assist the profession to isolate areas in which difficulties or misunderstandings could result. On June 25, 1966, at the Palmer House in Chicago, the American Medical Association will conduct a Seminar on Medicare to acquaint leaders in Medicine with the latest rules, regulations and interpretations that have developed.

The questions asked below are ones which have been repeatedly asked by physicians. Most of the answers are the result of opinion solicited from the Social Security Administration, or are AMA staff interpretations of the law and regulations. Obviously, there are still many unknowns and imponderables in the program. As experience is gained, it may be expected that changes will be made by SSA in both the regulations and the interpretation of those regulations. However, for the present time, the answers given below are the most accurate in view of present information.

ADMINISTRATION

Q. What is the role of the state agencies under the medicare program?

The role of the state agencies is to act on behalf of the Secretary of HEW in determining whether hospitals, extended care facilities, home health agencies, and independent laboratories within a state are in substantial compliance with the conditions for participation in the program. The state agency makes its recommendations to the Secretary of HEW who is charged with making the final determination of compliance.

Q. Can a physician who serves on a hospital or nursing home utilization review committee be compensated for his time?

There is no provision in the law for the payment of physicians who serve on utilization committees. However, since hospitals and nursing homes will be reimbursed for their reasonable costs in carrying out their functions under the

(Continued on Page 999)



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1. Weese, H.: Personal Communication, Sept. 25, 1964. 2. Glynn, R.: Obst. & Gynec. 20:369, 1962.

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(Continued from Page 997)

program, the cost of operating a utilization review committee could be a reimbursable expense. If the facilities compensate a physician for the time which he spends on the utilization review committee, the reasonable compensation could be included as part of the facility's reimbursable costs. It is unlikely, however, that physicians' services will be reimbursable under medicare if similar compensation is not made to physicians who serve on utilization review committees for the under 65 patients.

Q. What are the legal hazards for a physician serving on a utilization review committee? If the patient's hospitalization is terminated by the committee, can the physician be sued should the patient die or have a relapse?

The function of the utilization committee is to determine whether the patient's medical condition requires the continuation of benefits on an inpatient basis. Should the committee conclude that further institutional care is not required, it would notify the attending physician at which time he would be given an opportunity to consult with them. If the committee continues to maintain that further inpatient care is not required, payments under the program could not continue beyond the third day following such a decision. Since it is intended that the committee merely determines when payments under the program will cease and cannot discharge the patient from the facility, there would seem to be no legal liability for the physician who serves on this committee.

BENEFITS

Q. Is a person 65 years of age or older entitled to medicare benefits if he is not receiving Social Security or Railroad Retirement benefits?

Almost all individuals 65 and older who receive Social Security or Railroad Retirement benefits are eligible. Also, persons in that age category who are entitled to Social Security or Railroad Retirement benefits but are not receiving them because of earnings or for other reasons, are also eligible for medicare benefits. In addition, most individuals who will reach age 65 before 1968 would also be eligible regardless of whether they are eligible for Social Security or Railroad Retirement benefits. After 1968, some Social Security coverage will be required.

Q. When can a person enroll for Part B, the Supplementary Medical Insurance Benefits.

Individuals 65 or older by January 1, 1966, can enroll during the current enrollment period which ends May 31, 1966. If he becomes 65 after January 1, 1966, he will be covered when he reaches 65 if he has enrolled within the preceding three month period. Enrollment may also take place during the period of 3 months following the month in which the individual reached age 65.

Q. Under Part A of the medicare program an individual is entitled to up to 90 days of inpatient hospitalization during a "spell of illness." How long is a "spell of illness" under the medicare program?

A "spell of illness" begins on the first day an individual receives covered inpatient hospital services or nursing home services and ends after an individual has been out of the hospital or nursing home for 60 consecutive days. A patient may be discharged and readmitted several times during a spell of illness until such a time as benefits have been exhausted. After 60 consecutive days without inpatient services, a new spell of illness may begin with an entitlement of 90 days of hospitalization, and nursing home care.

Q. Will a patient who is admitted in an emergency situation to a hospital which is not

participating in the program be entitled to hospitalization benefits under the program?

The law permits the payment of benefits for emergency inpatient care or hospital diagnostic services in a non-participating hospital until such a time as it is no longer medically necessary to continue such care in the non-participating facility. The hospital would, however, have to agree to not charge the patient, except for the deductible and coinsurance, any amounts in addition to the amount paid for the covered services under the program.

Q. What benefits are included under Part A and Part B of medicare?

Under Part A, the following services are provided: 90 days of inpatient hospitalization per spell of illness, including nursing service, supplies and appliances and equipment, blood transfusions except the first 3 pints, medical social service, therapeutic services, operating room costs, drugs ordinarily furnished, diagnostic services, and the services of hospital residents and interns in approved training programs; 100 days of posthospital extended care services in a nursing home including nursing care, physical or other therapy, medical social services, and drugs, supplies, appliances, etc., ordinarily furnished; 100 posthospital home health visits including part-time nursing care, physical or other therapy, services of home health aides, medical social services, medical supplies other than drugs, and medical appliances, and, outpatient hospital diagnostic services with some limitations and co-payment features.

Under Part B, the following services are covered: Medical and surgical services by a physician wherever they are provided; dental surgery by a doctor of dental medicine or dental surgery; services in connection with a physician's treatment such as diagnostic tests, medical supplies, services of his nurse, drugs which cannot be self-administered, and similar services; other medical services and supplies such as diagnostic tests, prosthetic devices other than dental, certain ambulance services where required, X-ray and other radiation therapy, surgical dressings, splints, casts, etc., braces, artificial limbs, and other such devices; and home health services similar to those provided under Part A but without the requirement of previous hospitalization.

Q. What items and services are not covered either Part A or Part B?

Specifically excluded are: Prescription drugs and drugs which can be self-administered; routine physical examinations; dentures and care or replacement of teeth; hearing aids, eyeglasses, or orthopaedic shoes; immunizations except when administered in conjunction with treatment; private nursing; private hospital room except where medically necessary; personal comfort items; custodial care; health expenses charged by an immediate relative or a member of the patient's household; or items or services which are not reasonably necessary for the treatment of illness or injury or to improve the function of a malformed body member.

Q. What are the "deductibles" and "co-payment" requirements of the law?

Part A requires the patient to pay the first $40 cost of hospital care, and the first $20 of diagnostic study. Also under Part A he pays $5 per day for nursing home care after the 20th day and the cost of the first 3 pints of blood if they are not replaced. The program also requires the patient to pay 20% of the cost of diagnos-

(Continued on Page 1002)

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(Continued from Page 1000)

tic studies which exceed the $20 deductible. Part B requires the patient to incur the first $50 of covered expenses during any calendar year and to pay 20% of the "reasonable charges" in excess of the deductible.

Q. Will Medicare pay for private room accommodations in a hospital?

The basic hospital accommodations provided for by Medicare are semi-private accommodations, and these will be paid for in full. Private accommodations are paid for in full only where required for medical reasons. In other instances, the program would only pay the cost of a semi-private room with the extra charges paid by the patient.

Q. If a patient has a private duty nurse, will any portion of the costs for such nursing care be paid?

Medicare does not pay any portion of the cost of private duty nursing in the hospital. The patient would have to pay all costs for such services.

Q. Are drugs included under Medicare?

Briefly stated, Part A includes such drugs and biologicals as are often furnished by the hospital or extended care facility for the care and treatment of inpatients. Part B provides for the payment for drugs which cannot be self-administered and which are administered by the physician as incident to his treatment and are usually rendered either without charge or included in his bill for professional services.

Q. Can a patient be sent directly to a nursing home by his physician, without prior hospitalization?

The law requires that before a patient is eligible for benefits in a nursing home, he must have been a hospital inpatient for at least three days and, in addition, must be admitted to the nursing home within 14 days following discharge from the hospital. An individual may also be readmitted to a nursing home without hospitalization if the readmission takes place within 14 days of discharge from a nursing home.

Q. Can a patient be sent to the nursing home for any physical condition?

In order for the nursing home to be paid, the physician must certify that the services are required on an inpatient basis because the patient needed skilled nursing care on a continuous basis for any of the conditions with respect to which he was receiving inpatient hospital services prior to transfer to the nursing home facility. The nursing home may also be paid upon certification by the physician that the condition requiring such nursing home services arose after the transfer, but while the patient was in the nursing home for treatment of a condition for which he had received inpatient hospital services prior to the transfer.

PHYSICIAN COMPENSATION

Q. How will the physician know whether his patient has coverage under the Medicare program?

Each individual who presently qualifies and enrolls in the program will receive an identification card prior to July 1, 1966 when the program begins. This card will show whether the individual has supplementary coverage in addition to the basic hospitalization program.

Q. Who determines the amount payable under Part B for a physician's services?

It is the function of the carrier to determine the "reasonable charge" for a particular service performed by a physician. The law requires the charges for services be reasonable and not higher than the charge for comparable services under

comparable circumstances to the policyholders and subscribers of the carrier. The law further requires that in determining the reasonable charges there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.

Q. For purposes of determining "reasonable charges" has the United States been divided into geographic zones?

No such division has been made nor is it contemplated. The carriers are not expected to determine a "reasonable charge" on a regional or state level but rather to determine fee levels on a community by community (or area by area) basis. The Social Security Administration has further commented that it would not be unlikely that even within certain communities the "reasonable charge" for a certain procedure might be different between specialists and non-specialists.

Q. What is meant by "assignment" and "direct billing"?

There are two billing methods available to the physician who cares for patients under Part B of Medicare. He may choose to deal only with his patient. Under this arrangement, he would bill the patient in his usual manner and look solely to the patient for payment of his fee. The patient, upon presentation of a receipted bill, would seek reimbursement from the carrier for 80% of the "reasonable charge" as determined by the carrier. If, on the other hand, the physician accepts from the patient an assignment of his fee, the physician would seek 80% of the "reasonable charge" from the carrier and the remaining 20% from the patient. Under this latter method, and assuming that the patient has satisfied his annual deductible, the physician may not bill his patient for more than 20% of the "reasonable charge" for such service.

Q. May a physician's fee be greater than the "reasonable charge" as determined by the carrier under Part B?

If the physician uses the "assignment" method of billing his total fee for the service cannot exceed the "reasonable charge." If the physician bills the patient directly for his fee, he may charge the patient whatever fee he believes is appropriate regardless of what may be the carrier's determination of a reasonable charge.

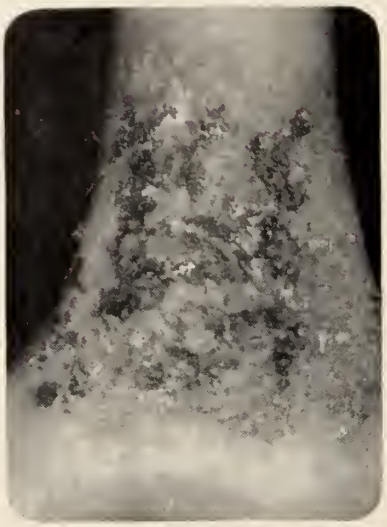
Q. Does the patient have to complete a special form to send to the carrier with the paid receipt to receive reimbursement under the direct billing method?

Regardless of the method of billing used, the patient must complete and sign Part I of the form SSA-1490, "Request For Payment" whenever a claim is incurred. Under the direct billing method, the individual would attach the physician's receipted bill to obtain reimbursement. If the physician accepts an assignment, he must complete and sign Part II of the form which would then be sent to the carrier for payment.

Q. Is there any provision for the reimbursement of consultants?

There are no special provisions for compensating consultants. However it may be expected that a consultant can be compensated on the same basis as would be any other physician performing a professional service.

eczema: scourge of childhood



R. R., Age 11—Before treatment—atopic eczema of long standing



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ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of childhood eczema: allergic, atopic, nummular, psoriatic, and mycotic.

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Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

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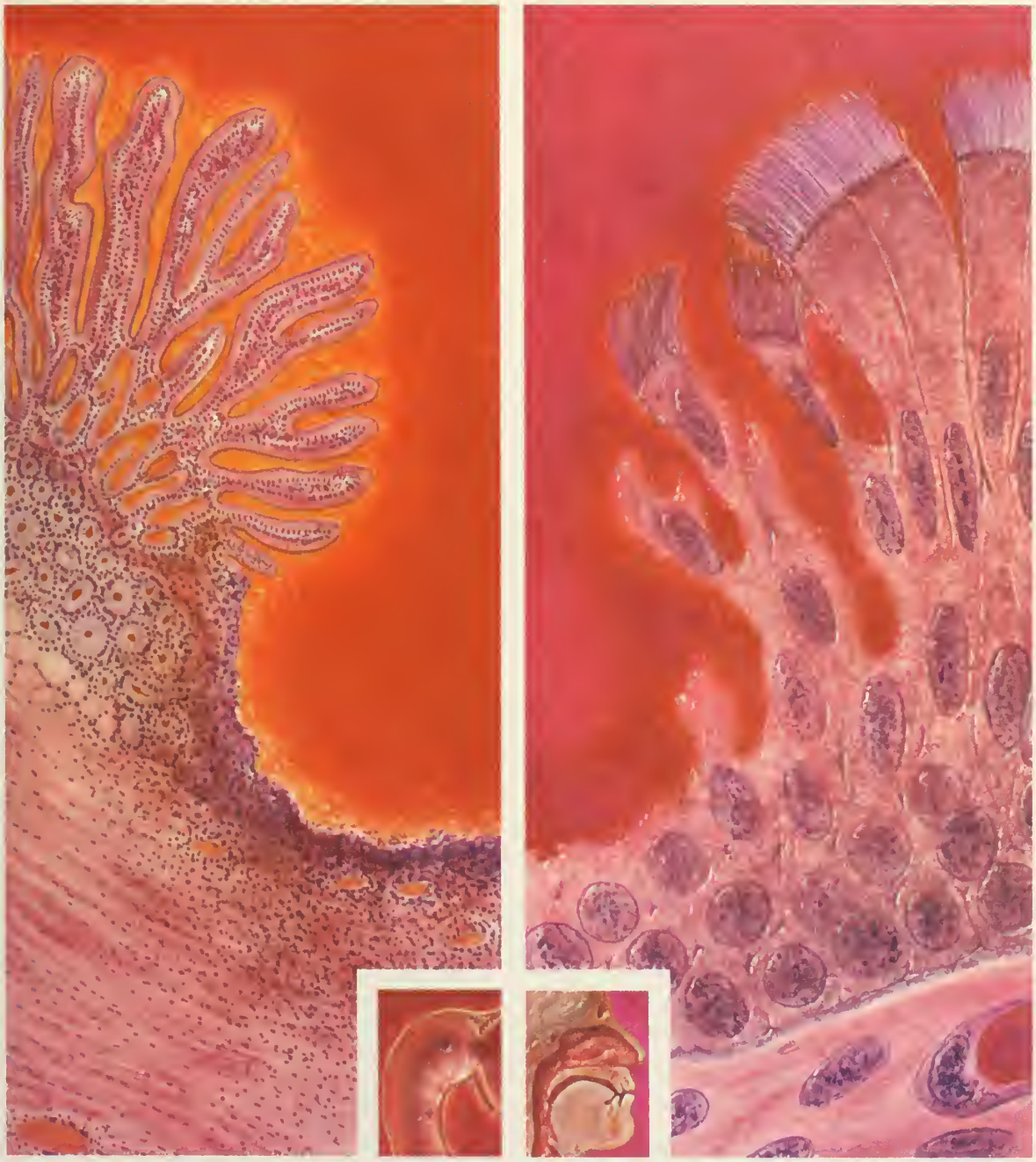
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Duodenal mucosa with ulcer crater—Approx. 80× Magnification.

Loosening epithelial cells of nasal mucosa during early stage of cold—Approx. 1800× Magnification.

this issue: partners in misery

Partners in misery: common cold and duodenal ulcer*



A century or two ago our forefathers believed that the common cold was caused by an excess of evil humors. Today we regard these baleful humors as a result of the cold rather than its cause. Only in the last ten years have some of the offending viruses been cultivated, and we now know many others can be transmitted to human volunteers although they cannot yet be grown in the laboratory. Various body defenses react to infection by a virus, and in the respiratory tract the lung is protected by the phagocytic properties of the pulmonary alveolar macrophage.[1]

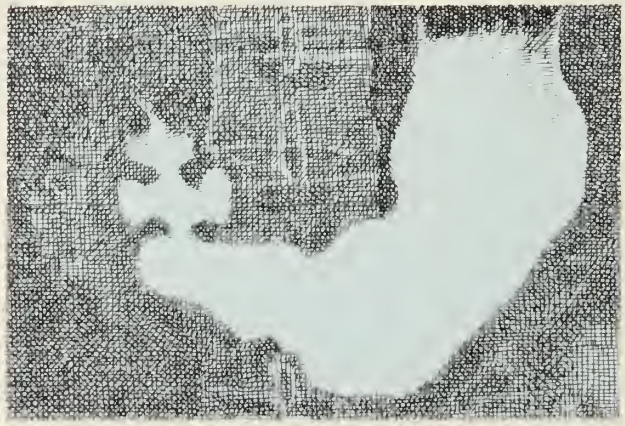
Because of the brief history and large proportion of unidentified viruses, effective prophylactic vaccines have not yet appeared. A universal antiviral agent seems even more remote. Meanwhile, these viruses continue to produce epidemics of upper respiratory infection at seasonal intervals, particularly in spring, fall and winter, during which they propagate and distribute progeny indiscriminately. As a result, they are responsible for significant work loss. Since the immunity afforded is temporary, recurrent infections are common.

This recurrent morbidity in spring and fall is shared by duodenal ulcer, itself a cause of significant loss in wages and medical expense. Thirty years ago Emery and Monroe reported 1,279 recurrences of peptic ulcer of which 13 per cent could be attributed to upper respiratory infection, thus confirming a long-held clinical impression.[2] While the inflammation, congestion and secretion of the mucosa of the nasopharynx in the common cold, and the hyperemia and hypersecretion of the gastric mucosa during acute exacerbation of a duodenal ulcer may not be directly linked, it is probable that the miseries of the infection are reflected in the pain of the ulcer. The following case history illustrates this point.

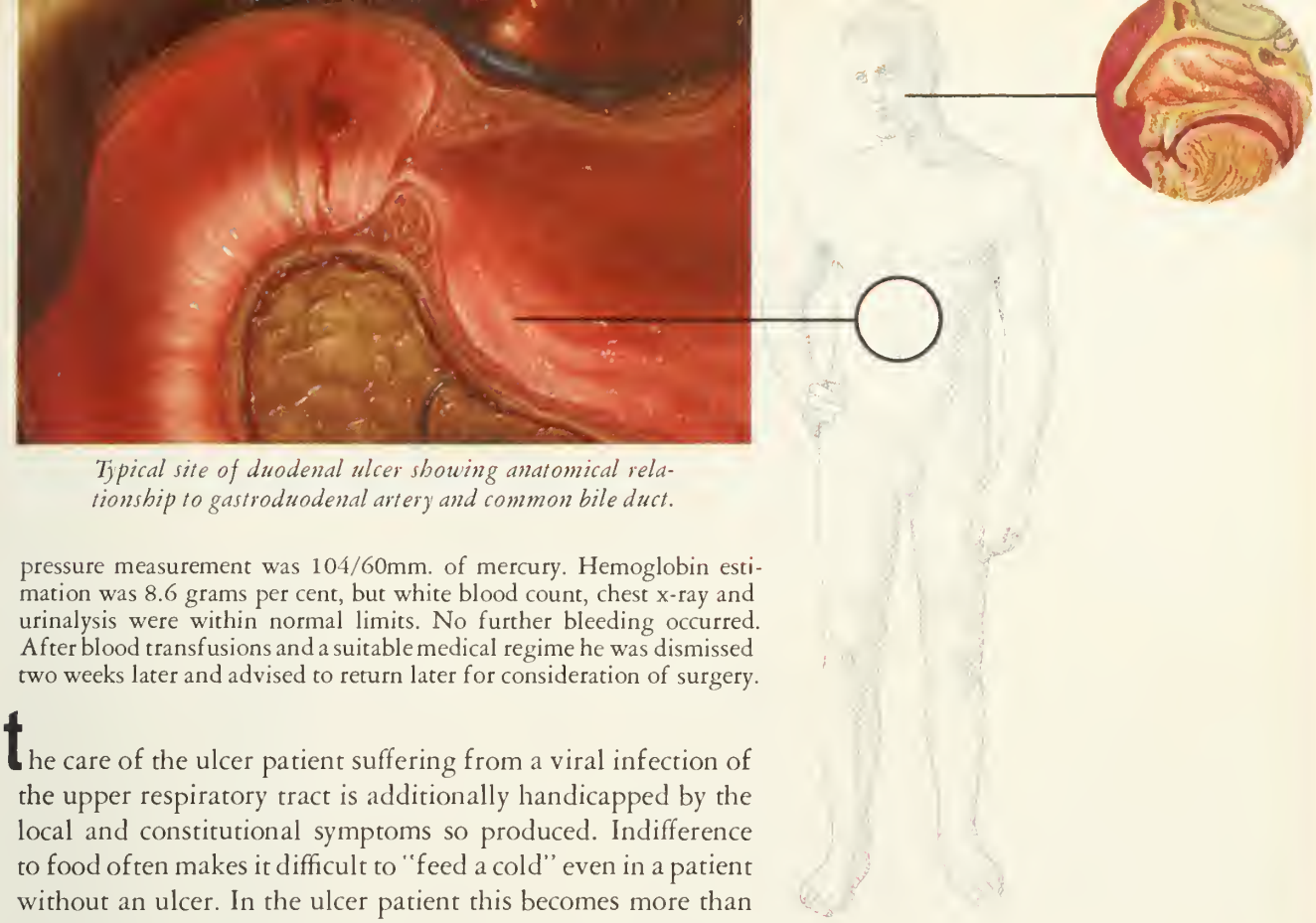
Case report A 48 year old white male executive, suffering from hematemesis and melena for 12 hours was admitted to hospital on April 8, 1965. He gave a history of duodenal ulcer proved by x-ray studies 23 years previously. In the intervening years he suffered from typical epigastric pain occurring two hours postprandially, usually for two or three weeks each spring and fall. A hospital admission two years earlier had followed hematemesis of moderate amount.

The present admission was preceded by a recurrence of pain during a period of unusual business pressure. In addition he caught a cold one week before his entry to hospital and his already irregular eating habits were made more so by loss of taste and appetite, blocked nose and general malaise. During the final 36 hours he used aspirin to relieve his cold, taking 2 or 3 tablets with a glass of water on 6 or 7 occasions. Before retiring he drank a glass of hot toddy.

He awakened about 1 a.m. and vomited dark red blood and recently ingested food mixed with whisky. Melena followed and he was transferred to hospital. On admission he was pale, cold and sweating. Apart from epigastric tenderness and black stool on the examining finger after rectal examination, his general physical examination was not remarkable. Temperature was normal, pulse was thin and thready with a rate of 114 beats per minute, and blood



The commonly found "clover-leaf" roentgenographic abnormality of chronic duodenal ulcer due to spastic contractions and scarring.



Typical site of duodenal ulcer showing anatomical relationship to gastroduodenal artery and common bile duct.

pressure measurement was 104/60mm. of mercury. Hemoglobin estimation was 8.6 grams per cent, but white blood count, chest x-ray and urinalysis were within normal limits. No further bleeding occurred. After blood transfusions and a suitable medical regime he was dismissed two weeks later and advised to return later for consideration of surgery.

The care of the ulcer patient suffering from a viral infection of the upper respiratory tract is additionally handicapped by the local and constitutional symptoms so produced. Indifference to food often makes it difficult to "feed a cold" even in a patient without an ulcer. In the ulcer patient this becomes more than a homily, for malaise and apathy towards irksome routine produce a lack of interest in adhering to an ulcer program and result in its eventual failure if these symptoms are not relieved. The absence of curative treatment for these viral infections has spawned many a strange therapeutic offspring and some of the more generally accepted remedies contain a special risk for the ulcer patient.

To the gastric physiologist, the shot heard around the world was not fired at Concord but was discharged through the stomach of Alexis St. Martin. The worthy voyageur had a more than modest thirst and on several occasions William Beaumont observed through the resulting fistula the changes of gastritis which followed an immoderate ingestion of alcohol.[3] It is now well known that alcohol stimulates the production of gastric juice and the patient with an ulcer, even in remission, should not drink alcohol without first taking food, milk or antacid. The use of various alcoholic remedies for the common cold is to be strongly discouraged in this type of patient. Factors already present can produce an acute exacerbation of ulcer symptoms without the added stimulus of alcohol.

Headache and facial pain, sore throat and generalized aching are subjective discomforts of viral infections of the upper respiratory tract or their complications. Relief from them is usually sought in the family medicine cabinet, and of all the medications habitually stored there, salicylates are the most frequently used. Oral ingestion of salicylates has produced



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substernal pyrosis and sometimes epigastric pain in susceptible individuals. Bleeding from erosions of the gastric mucosa has followed their use and has been severe enough in some instances to cause hematemesis and melena.[4] It has been suggested that interference with the protective mucous layer of the stomach allows this to happen. There is no evidence that hypersecretion occurs, but the taking of aspirin has been followed by exacerbation of ulcer symptoms and occasionally by gastrointestinal bleeding.[5] The ulcer patient with a cold should take salicylates with an antacid, or preferably other means of symptomatic relief should be found.

Caffeine has two actions on gastric secretion. One directly stimulates production of acid and the other potentiates the out-pouring of gastric juice as a response to other stimuli.[6] In high doses to animals, it has produced erosive gastritis and peptic ulceration. Caffeine-containing beverages are discouraged for the ulcer subject and forbidden during an acute exacerbation.[7] Many cold remedies contain caffeine.

To sufferers from allergic rhinitis springtime brings symptoms of nasal obstruction, loss of taste and smell and malaise similar to those caused by viral infection but due instead to allergens which at that time of year are principally tree pollens. Relief from these symptoms can be obtained, though not wisely, by the use of steroid medication. Unfortunately, chronic sufferers from these allergies have used this approach with varying degrees of success. Steroid hormones increase gastric secretion and delay the healing of experimental ulcers.[8,9] Clinically their administration has been associated with reactivation of healed duodenal ulcers, and with bleeding and perforation which were not always preceded by typical ulcer distress. Because of these harmful effects, their use in the ulcer patient is best avoided for other than serious medical problems and then only with adequate antacid coverage.

Summing up It is immaterial by which pathways the malaise and lassitude, depression and irritability activate an ulcer, but it is the physician's responsibility to ensure that the medications he selects to relieve the symptoms of a cold do not further aggravate the ulcer.

References 1. Divertie, M. B. and Brown, A. L., Jr.: The Pulmonary Alveolar Macrophage. Med. Clin. N. Amer. 48:1049-1054, July, 1964. 2. Emery, E. S., Jr. and Monroe, R. T.: Peptic Ulcer: Nature and Treatment Based on a Study of 1,435 Cases. Arch. Int. Med. 55:271, 1935. 3. Osler, W.: Experiments and Observations on the Gastric Juice and the Physiology of Digestion by William Beaumont, M. D. XIII Internat. Physiol. Congress. Boston, Massachusetts. pp. 280, 1929. 4. Leonards, J. R.: Aspirin and Blood Loss From the Gastrointestinal Tract. Fed. Proc. 21:452, 1962. 5. Kossover, M. F. and Kaplan, M. H.: The Role of Salicylates in Massive Gastrointestinal Hemorrhage. Am. J. Gastroenterology. 35:445-455, 1961. 6. Roth, J. A. and Ivy, A. C.: Synergistic Effect of Caffeine on Histaminic Response. Am. J. Physiol. 142:107, 1944. 7. Musick, V. A., Avey, A. T., Hopps, H. C. and Hellbaum, A. A.: Gastric Secretion in Duodenal Ulcer in Remission; Response to the Caffeine Test Meal. Gastroenterology. 7:332, 1946. 8. Kahn, D. S., Phillips, M. J. and Skoryna, S. C.: Healed Experimental Gastric Ulcer in the Rat; Re-Ulceration Resulting from Cortisone Administration. Amer. J. Path. 38:177-187, 1961. 9. Chaikof, L., Janke, W., Pesaros, P. C., Ponka, J. L. and Bush B. E.: Effects of Prednisone and ACTH on Gastric Secretion. Arch. Surg. 83:32-39, 1961.

*Author's name on request.

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65 Students At Medical College Get Scholarships

Scholarship awards and loans totalling $130,000 have been approved by the Alabama Board of Medical Scholarship Awards for 65 students at the Medical College of Alabama. Each scholarship is valued at $2,000.

Eight scholarships were awarded for academic superiority and are non-refundable. Fifty-two others are loans repayable upon completion of medical studies either in cash or by practicing in a community deemed by the Board to be critically in need of a physician.

The Medical Scholarship Law enacted by the Alabama Legislature last year also provided for two annual scholarship loans of $5,000 each for physicians desiring to pursue postgraduate studies in public health. The loans are repayable in cash or by service in a State institution, the Department of Public Health or a county health department for a stipulated period of time. Because there were no applicants for these loans this year the Board divided the amount among five additional students, as the law permits.

The list of recipients follows:

MERIT SCHOLARSHIPS

Freshmen	City	County
Omer Lee Burnett	Goodwater	Coosa
Raymond Lyrene	Silverhill	Baldwin
Sophomores		
William A. Hill	Winfield	Marion
Terry B. Cooper	Gadsden	Etowah
Juniors		
Charles B. Dahlke	Aliceville	Pickens
James S. Sullivan	Northport	Tuscaloosa
Seniors		
William T. Branch	Montgomery	Montgomery
Bonnie Maloy Embry	Bessemer	Jefferson

SCHOLARSHIP LOANS

Freshmen	Home town	County
John Akridge	Hueytown	Jefferson
John Campbell	Lineville	Clay
Bry Coburn	Mobile	Mobile
George Fisher	Birmingham	Jefferson
Gary Gross	Athens	Limestone
Samuel Miller	Cedar Bluff	Cherokee
Shepherd Odom	Auburn	Lee
James Rains	Montgomery	Montgomery
James Scarborough	Florence	Lauderdale
James W. Smith	Athens	Limestone
Samuel Sullivan	Birmingham	Jefferson
Philip Walton	Gadsden	Etowah

SCHOLARSHIP LOANS

Sophomores		
Charles Conner	Highland Home	Crenshaw
Roddy Cook	Dothan	Houston
William Edge	Jasper	Walker
Ronald Hilyer	East Tallassee	Tallapoosa
Eddie Lamon	Muscle Shoals	Colbert
Milton Lennicx	Robertsdale	Baldwin
Franklin Long	Canoe	Escambia
Marilyn McRae	Montgomery	Montgomery
Gaylon McCollough	Birmingham	Jefferson
Ronald Olivet	Tuscaloosa	Tuscaloosa
Milton Raines	Tuskegee	Macon
Martin Stallings	Hartford	Geneva
Horace Thompson	Bynum	Calhoun
William Walley	Guntersville	Marshall
Howard Harper (1 yr.)	Mobile	Mobile
Bobby Holt (1 yr.)	Remlap	Blount
Dewey Jones (1 yr.)	Adger	Jefferson
Philip Newton (1 yr.)	Mobile	Mobile
Juniors		
Robert Bentley	Columbiana	Shelby
Kirby Bland	Abbeville	Henry
Kenneth Copeland	Gadsden	Etowah
Wayne Coxwell	Jackson	Clarke
Lawerence Farris	Elba	Coffee
Harold Gebhart	Foley	Baldwin
John Jeffers	Auburn	Lee
Gillis Payne	Greensboro	Hale
Elliott Monroe	Clanton	Chilton
Harry Prim	Dothan	Houston
Perry Savage	Piedmont	Calhoun
Terrell Spencer	Birmingham	Jefferson
William Watson	Brundidge	Pike
George Thomas (1 yr.)	Birmingham	Jefferson
Seniors		
James Austin	Wetumpka	Elmore
John Blythe	Alexander City	Tallapoosa
W. Pearson Clack	Roanoke	Randolph
Gerald Cochran	Crossville	DeKalb
L. Jan Davis	Huntsville	Madison
Robert E. Hill	Alpine	Talladega
Lennox Larrimore	Dickinson	Clarke
James C. Matthews	Silas	Choctaw
Knut E. Mueller	Foley	Baldwin
Gerald New	Wedowee	Randolph
Bruce Russell	Cordova	Walker
Lee Taylor	Sheffield	Colbert
Barry Wilson	Wedowee	Randolph

Arthritis Clinic Receives Fund From Junior League

The Alabama Chapter, Arthritis Foundation, has received a financial grant from the Junior League of Birmingham amounting to $8,000 per year for a three-year period, a total of $24,000. It will be used by the Arthritis Clinic at University-Hillman Hospital to streamline the clinic for indigent arthritics as well as to finance laboratory and X-ray facilities.

MEDICINE AND THE BIBLE

C. Truman Davis, M. D., M. S.



Most of us visualize history as a series of events superimposed upon a time line. This article will consist of a series of medico-historical vignettes from the Bible superimposed upon a time line extending from 2000 B. C. to the First Century A. D.

This approach, though it will unfortunately preclude our studying any era or any subject in depth, will enable us to achieve certain objectives: It will give us a view of medicine from the very dawn of history; it will throw light on some of the fascinating medical events of the Old Testament; it will give us a background for better understanding medicine in the Christian era.

Let us begin with Abraham, the father of the Hebrew people. Remember, Abraham came from Ur in Chaldea—later to be called Babylonia. We get a glimpse of medicine in this era through the famous code of Hammurabi—preserved in cuneoform writings and almost exactly contemporary with Abraham.

Concerning the wounds resulting from operations it is written in the Code: "If a physician shall produce on anyone a severe wound with a bronze operating knife and cure him, or if he shall open an abscess with the operating knife and preserve the eye of the patient, he usually shall receive ten shekels of silver; if it is a slave, his master shall usually pay two shekels of silver to the physician.

"If a physician shall make a severe wound with an operating knife and kill him, or shall open an abscess with an operating knife and destroy the eye, his hands shall be cut off.

"If a physician shall make a severe wound with a bronze operating knife on a slave of a free man and kill him, he shall replace the slave with another slave. If he shall open an abscess with a bronze operating knife and destroy the eye, he shall pay the half of the value of the slave.

"If a physician shall cure a diseased bone or a diseased organ, he shall receive five shekels of silver; if it is a matter of a freed slave, he shall pay three shekels of silver; but if a slave, then the master of the slave shall give to the physician two shekels of silver."

In this same code are indicated with a particular exactness the diseases of the slave which can annul the validity of a lay contract; two of these are cited frequently under the names of "bennu" and "siptu," identified by some as epilepsy and leprosy. The expulsion of lepers from the community—"Nevermore shall he know the ways of his abiding place"—indicates that the Babylonians were aware of the contagiosity of leprosy and took measures to combat it.

We shall now move without event through half a millenium. Parenthetically, let us realize that we tend to pass blythely over long time spans when they occur in the distant past. Five hundred years is longer than the white man has inhabited the American continents.

You are, of course, familiar with the story of Joseph, his entrance into Egypt as a slave and eventually becoming a high official in Pharaoh's court.

Following Joseph, there occurred a migra-

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2000 B. C.	1500 B. C.		1141 B. C.	1095 B. C.	1013-973 B. C.
Babylonia Abram (Abraham) King Hammurabi	Egypt Ebers & Edwin Smith Papyri Moses—Desert Wanderings Sanitary Code		Samuel Warfare with the Philistines	Saul	Nabal King David
680 B. C.	588 B. C.	520 B. C.	445 B. C.	460-350 B. C.	400-300 B. C.
Sennacherib Isaiah—King Hezekiah	The Captivity in Babylon	Return from Captivity Temple Rebuilt	Nehemiah Walls of Jerusalem Rebuilt	Hippocrates	Greek Influence
190 B. C.	200-55 B. C.		5 B. C.-29 A. D.	80 A. D.?	
Apocrypha	Mediterranean World Falls Under Roman Rule		Jesus the Christ Loukanos the Physician	Paul of Tarsus	

Time Line

tion of the Hebrews into Egypt. At first they were a favored people, but eventually "there arose up a new king over Egypt which knew not Joseph" (Exodus 1:8) and the people were enslaved.

Then we come to Moses, a Hebrew, reared as a prince of Egypt, educated in Pharaoh's palace. What medical knowledge did he have available to him? Here we have excellent examples of at least the *minimum* medical knowledge available. Two well-preserved medical texts—the most ancient known to man, are the Ebers and Edwin Smith papyri, found in a tomb in Thebes in 1862.

We have no idea of the *possible* knowledge which could have been available, since these are isolated writings. Suppose an archaeologist 3500 years from now unearthed a text on chiropractic or a folk medicine book by a physician advocating honey and vinegar for all ailments, and had no other material available concerning medicine in our age. This would hardly give a valid picture of twentieth century medicine.

The Edwin Smith papyrus, a treatise on wounds and injuries, gives a clear description of forty-eight cases. For example: "A gaping wound of the head, smashing the skull," then follows a description of signs and symptoms and methods of examination. Finally the writer gives a prognosis by saying, "A wound I will treat" or "A wound I will not treat." The treatments were straightforward, without magic or incantation. Cautery was advocated for controlling hemorrhage, a technique which, as we know, is still used in many surgical procedures today. Gaping wounds were brought together with adhesive plaster, and some authorities believe sutures were used. In a skull fracture, with a fragment of bone pressing against the brain, elevating the fragment was advised just as is done in modern neuro-surgical practice today. A perforating wound into the esophagus was tested by having the patient drink water and seeing if it came out through the wound; realistic for that day, but fortunately, better methods are available today. Very accurate descriptions of methods to reduce a dislocated joint were given. The method advocated for the reduction of a dislocated jaw is precisely that used today. A splint consisting of a roll of stiff material was advised for broken bones. The Egyptians had a name for the internal organs of the body but knew nothing of their real function. However, a section of the papyrus does describe the pulse and its association with heart action. This was three thousand years before the circulation of the blood was described by Harvey!

Let us now examine the sanitation laws of Moses as recorded in Deuteronomy and Leviticus; the most enlightened public health

rules known to man until the Twentieth Century. On the march, during the forty years in the wilderness, strict laws for the preparation of food, the purification of water supplies, and the disposal of human waste were enforced. This, with no knowledge of bacteria and their function in the cause of disease. Later, after cities were occupied, rigid rules for the burial of the dead and the burning of refuse were enforced without knowing anything about the role of the fly in carrying disease.

Strict sexual morality kept venereal disease under control and there were elaborate rules for the ostracizing of lepers. The Hebrews also realized that certain cases of "leprosy" seemed to get well, so criteria were established for examination by a priest and being declared clean. We now know that these so-called "cured" cases were some form of skin disease other than leprosy.

There were innumerable incidents related in the Old Testament that have medical significance. We will discuss just a few and attempt to analyse them in the light of modern medical science:

In the First Book of Samuel there is a fascinating story. The Philistines had defeated the Israelites in battle, had captured the Ark of God and put it in one of their pagan temples. No worse desecration was conceivable to the Hebrews and they were demoralized. Then, "The hand of the Lord was heavy upon them of Ashdod, and He destroyed them and smote them with emerods*" (I Samuel, 5:6). In the Greek Septuagint there is added: "And the land swarmed with mice." (H:Akbar—mice, rats.)

The Philistines believed that this plague was a judgement on them for taking the sacred ark of the Hebrews, so they put it in a cart pulled by two milk cows and sent it back to the Hebrew lines. The most intriguing part of this story is that the priests ordered that ten golden images be sent back with the ark—five images of the tumors and five of mice. Here we have a classical description of the bubonic plague. The bacillus of plague is carried by the rat flea; when the rat dies the fleas leave the body. If the flea then bites a human, the disease can be transmitted to the bloodstream of the new host. The Philistines apparently knew the association of rats with the plague—something which modern medicine didn't discover until the end of the Nineteenth Century!

An excellent clinical description of apoplexy, or stroke, is given in the account of the death of Nabal in the First Book of Samuel. After he had offended King David, Nabal went home and drank himself into a stupor. "And it came to pass in the morning, when the wine was gone out of Nabal, that his wife told him of these things, that his heart died within him and he became as a stone. And it came to pass about ten days after that the Lord smote Nabal, and he died"; (I Samuel, 25-37-38). The ancient Hebrews did not understand the function of the brain and associated unconsciousness with the heart. The bad news, possibly associated with an elevation in blood pressure, causing a sudden loss of consciousness and death ten days later forms a characteristic picture of a cerebrovascular accident.

King Saul would be diagnosed today as a typical example of manic depressive psychosis. The periods of extremely productive activity alternating with periods of deep gloom are classical for this type of insanity. The outbreaks of homicidal violence for no particular reason (as when he hurled the javelin at David), the delusions that David and the people were plotting against him, together with his terminal suicide, are unmistakable.

One of the most dramatic plagues of all recorded history is described in the Second Book of Kings. The powerful Assyrian army, under the leadership of their king, Sennache-

*The word **ophalim** was translated in the Authorized Version as "emerods" or hemorrhoids. It simply means a swelling or tumor and is so translated in later versions. It could easily, therefore, refer to the discrete swelling in the groin produced by the adenopathy of bubonic plague.

rib, had invaded Judah. We know from recent archaeological findings that the walled cities of Judah fell one by one before the might of the engines of destruction of the Assyrians. Finally only Jerusalem stood in the way of the conquerors. This great army with its chariots, its wheeled battering rams, its scaling ramps, and heavily armored soldiers, moved into position around the great stone walls of Jerusalem. Behind the army came the wagons with food and water to supply the troops. Then; "And it came to pass that night, that the angel of the Lord went out, and smote in the camp of the Assyrians an hundred fourscore and five thousand: and when they arose early in the morning, behold, they were all dead corpses," (II Kings 19:35). Thus, overnight, 185,000 fighting men died. It is interesting that very elaborate accounts of victories over the Judean cities were recorded, but there was no mention of Jerusalem. Ancient kings did not have their defeats written on clay tablets or stone.

Lord Byron was intrigued by this fascinating story from the Old Testament and gave us a colorful poetic description of the event:

The Assyrian came down like the wolf on the fold,
And his cohorts were gleaming in purple and gold;
And the sheen of their spears was like stars on the sea,
When the blue wave rolls nightly on deep Galilee.

Like the leaves of the forest when summer is green,
That host with their banners at sunset were seen:
Like the leaves of the forest when autumn hath blown,
That host on the morrow lay withered and strown.

For the Angel of Death spread his wings on the blast,
And breathed in the face of the foe as he passed;
And the eyes of the sleepers waxed deadly and chill,
And their hearts but once heaved, and forever grew still!

And there lay the steed with his nostril all wide,
But through it there rolled not the breath of his pride:
And the foam of his gasping lay white on the turf,
And cold as the spray of the rock beating surf.

And there lay the rider distorted and pale,
With the dew on his brow, and the rust on his mail;
And the tents were all silent, the banners alone,
The lances uplifted, the trumpet unblown.

And the widows of Ashur are loud in their wail,
And the idols are broke in the temple of Baal;
And the might of the Gentile, unsmote by the sword,
Hath melted like snow in the glance of the Lord!

The Destruction of Sennacherib.
From "Hebrew Melodies"
Lord Byron.

What could have been the etiological agent? Short suggests two possibilities, pneumonic plague and cholera. The pneumonic form of bubonic plague can certainly kill rapidly, but it would not be likely to move through an army in epidemic proportions if they were camped in the open with minimal close contact. Cholera, on the other hand is a "natural" for this situation. Ancient pagan armies had no concept of field sanitation. One or more cholera victims could have

grossly contaminated a water supply by feces and vomitus. The water skins, and possibly also great casks, which were to supply water to fighting men in this hot semi-arid land were then filled from the contaminated source; thus a lethal does of Vibrio comma, the bacillus of cholera, was meted out to the entire army several days prior to the seige. The symptoms struck suddenly—marked vomiting and diarrhea with very rapid dehydration and death.

The Biblical account continues by stating that Sennacherib returned to Nineveh, his capital city, and that while in his chapel praying to his pagan god, one of his sons ran him through with a sword. Certainly the disaster at Jerusalem marked the beginning of the end for the Assyrian Empire. It rapidly declined and broke up, to be replaced by the Babylonians.

The events shown on the time-line covering the next two centuries are primarily to keep oriented. We can see that Hippocrates, "The Father of Medicine," lived on the Island of Cos at about the time of Nehemiah in Jerusalem.

During the succeeding several centuries, following the conquests of Alexander, the entire Middle East came under the influence of Greece, not just politically, but culturally and commercially. As a matter of fact, long after political power had passed from Greece to Rome, the language of culture and of commerce was Greek.

Let us return to the Bible and read a delightful passage from The Apocrypha written during this era, probably about 190 B. C.:

"Honour a physician with the honour due unto him for the uses which ye may have of him: for the Lord hath created him.

For of the most High cometh healing, and he shall receive honour of the king.

The skill of the physician shall lift up his head: and in the sight of great men he shall be in admiration.

The Lord hath created medicines out of the earth; and he that is wise will not abhor them.

Was not the water made sweet with wood, that the virtue thereof might be known?

And he hath given men skill, that he might be honoured in his marvellous works.

With such doth he heal (men), and taketh away their pains.

Of such doth the apothecary make a confection; and of his works there is no end; and from him is peace over all the earth.

My son, in thy sickness be not negligent: but pray unto the Lord, and he will make thee whole.

Leave off from sin, and order thine hands aright, and cleanse thy heart from all wickedness.

Give a sweet savour, and a memorial of fine flour; and make a fat offering, as not being.

Then give place to the physician for the Lord hath created him; let him not go from thee, for thou hast need of him.

There is a time when in their hands there is good success.

For they shall also pray unto the Lord, that he would prosper that, which they give for ease and remedy to prolong life.

He that sinneth before his Maker, let him fall into the hand of the physician."

Ecclesiasticus, 38:1-15.

That last verse is disturbing, especially to a physician. Does it mean that to fall into the hands of a physician is a well-merited judgement on the sinner or does it mean that the punishment of his wrong-doing is tempered by the hope of medical relief? The Hebrew version, discovered in 1896, fortunately casts more light. It is translated thus: "He that sinneth against God will behave arrogantly before his physician."

(Continued on Page 1016)



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Now we come to the time of Jesus—the New Testament era.

A more personal and intimate means of studying this era is to discuss what a well-trained physician of this period would have known and what techniques he would have had available. We fortunately have an ideal example—one who played a major part in writing the New Testament. The author of one of the Gospels and of the Book of Acts of the Apostles was the Greek physician Loukanós, whom we know today as St. Luke. There is little doubt about St. Luke's profession. St. Paul refers to him as "the beloved physician." We are not taking too much license to conjecture that he was well-trained. The style of his writing is that of an educated man. Where medical description is given, it is meticulously accurate. Luke uses a total of twenty-three Greek technical words found in Hippocrates, Galen and other medical writings of the period, but no where else in the New Testament.*

Remember, Greek influence had spread over the entire Middle East and with it the medical knowledge which had been formulated by Hippocrates and his followers. In addition, the Romans had developed a fairly high degree of skill in traumatic surgery, primarily due to the experiences of their military surgeons. The Middle East also was a cross roads for the exchange of knowledge from Syria and Persia, where many empirical medical skills had been known for centuries. Luke was able to draw on all of these sources of knowledge.

To enumerate only a few of several hundred diseases which the Hippocratic Corpus describes very accurately: signs, symptoms, treatment, prognosis, etc.:

The description of malaria is a classical one which is exactly the same as our medical text books give today except that we, of course, know that the cause is a micro-organism carried by the anopheles mosquito and not by "bad air." Tuberculosis is described in accurate detail. A very complete system for the setting of broken bones and the reduction of dislocated joints is almost indistinguishable from our treatment of these disorders today. Trephining of the skull for hemorrhage is described, even to the minute detail of advising keeping the trephine cool with water. We know to keep saline flowing over our trephine in neuro-surgical procedures today so that bone cells are not killed and healing is not delayed.

The Hippocratic surgeons operated on the eye for cataract, though it was the procedure of couching, in which the opaque lens was pushed back into the vitreous by a needle rather than being removed through an incision as is done today.

Physicians in the Hippocratic tradition knew empirically the advantage of the use of wine or boiled water in surgical procedures and in dressing wounds, without, of course, having the remotest idea of micro-organisms and their role in producing infection.

These examples help to give us some glimpse of the knowledge and skill of St. Luke and his medical colleagues.

No discussion of medicine and the New Testament would be complete without con-

*An entire book with extensive study of Luke's medical terminology has been prepared by Hobart. However, many of the words which he discusses were possibly a part of the vocabulary of any educated man of that day and not used solely by physicians. It is felt by some scholars that his case is overdrawn.

sidering a condition which has received a great deal of attention, and has evoked a great deal of controversy: St. Paul's "thorn in the flesh" (II Cor. 12:17). "A thorn in the flesh" has since become a proverbial expression, but for Paul it was obviously a literal bodily ailment. Most scholars consider the condition some type of chronic ailment which was painful, intermittently disabling, and apparently somewhat disfiguring.

Numerous diagnoses have been advanced over the centuries, including epilepsy, recurrent malaria, rheumatoid arthritis, etc. None of these can be considered very seriously when we attempt to make a diagnosis from the patient's own history. There is one condition which best fits the New Testament account when we listen to Paul's own words and analyze them with the help of modern medical science. We know that on the road to Damascus, Paul lost his sight. Later, in the city, his vision returned, but it is questionable whether he ever saw well again. Most of his letters were dictated and written by a companion, though at the end he would add a few words in his own hand. To the Galatians he wrote, "Look at these huge letters I am making in writing these word to you with my own hand" (Phillips translation of Gal. 6:11). He also wrote to the Christians at Galatia, "You know how handicapped I was by illness when I first preached the gospel to you. You did not shrink from me or let yourself be revolted at the disease which was such a trial to you . . . I guarantee that in those days you would, if you could, *have plucked out your eyes* and given them to me (Phillips translation of Gal. 4:13-15). This, also, has become a figure of speech, but it may well have meant that his eyes were affected, and that he had to stop, unexpectedly, on his journey.

On one occasion, Paul spoke out strongly against a person who had ordered that he be struck in the mouth. It was necessary to tell him that it was the high priest who had given the order, implying that Paul was unable to see well enough to recognize a familiar figure at fairly close range (Acts 23:2-5).

A simple explanation of all these passages is that Paul had some disease of the eyes which intermittently flared up, was repulsive to look at, and interfered with his sight. Trachoma, a chronic and intractable form of keratitis and conjunctivitis exceedingly common in the Orient and Near East, would correspond exactly. This would cause marked irritation, pain and tearing. In addition, the cornea would become scarred, producing marked loss of sight.

You may have wondered why, in this discussion of diseases and medicine in the New Testament era that the miracles of Jesus were not discussed. Many attempts have been made by modernist scholars to explain the miracles in the light of modern medical science. The healing miracles are explained as psycho-somatic phenomena; raising the dead as the waking of persons from a cataleptic trance; the feeding of the five thousand as mass hypnosis, etc. Even attempts have been made to make the resurrection fit known physical laws; that is, that Jesus really wasn't dead but was in deep shock, and that after being placed in the tomb with the shroud wrapping His body, He revived and was alive for forty more days until finally infection from His deep wounds killed Him.

All of these explanations are made with the premise that Jesus was only a man and are, at best, transparent and very flimsy. The point is that the miracles are not the activity of a man, but, of God incarnate in human flesh. As such, they are miracles to us because they were performed by the One who ordained this particular system which we call the "laws of the Universe" and who was and is in no way limited by that *created system.*

Therefore, I am convinced that the water at Cana was turned into the finest wine; that the lepers were healed and their rotting flesh made healthy *instantly;* and that He who did these things truly died on the Cross, came to life on the third day in a completely changed body, ascended, and lives today . . .

(Continued on Page 1019)

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BIBLIOGRAPHY

The Old and New Testaments and the Apocrypha of the Holy Bible.

Adams, Francis: The Genuine Works of Hippocrates. The Williams and Wilkins Co., Baltimore, 1939.

Castiglioni, Arturo: A History of Medicine. Alfred A. Knopf, N. Y., 1947.

Chiera, Edward, and Cameron, George G.: They Wrote on Clay. The University of Chicago Press, 1938.

Hobart, William K.: The Medical Language of St. Luke. Hodges, Figgis and Co., Dublin, 1882. (Reprinted 1954, Baker Book House, Grand Rapids, Mich.)

Noyes, Carleton: The Genius of Israel. Houghton Mifflin Co., New York, 1924.

Pritchard, James B.: Archaeology and the Old Testament. Princeton University Press, Princeton, N. J., 1958.

Randolph, Howell: Personal communication. "Surgical Therapy Recorded in the Early Egyptian Period," excerpts from a speech to the Phoenix Society for the History of Medicine, March 4, 1961.

Short, A. Rendle: The Bible and Modern Medicine. The Paternoster Press, Exeter, Devon, England, 1953.

Thompson, J. A.: Archaeology of the Old Testament, Pre-Christian Centuries and the New Testament. Wm. B. Eerdmans Pub. Co., Grand Rapids, Mich., 1957.

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James Marion Sims, A. B., M. D., LL. D.

(1813-1883)

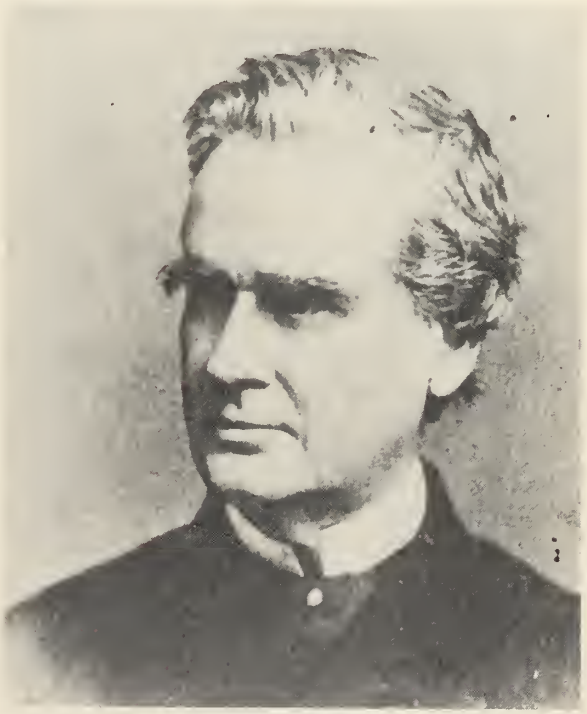
James Pratt Marr, M. D.

In the history of medicine in America, the name of James Marion Sims, commands respect and even a measure of reverence, for he was one of the founders of modern gynecology.

It has been stated that it was the challenge of vesico-vaginal fistula that, in a large measure, established the incentive and provided the stimulus for the creation of the earliest special hospitals for Women.

It is the purpose of this essay to review the gynecological interest, surgical exploits and the uncanny predictions of James Marion Sims, at the Woman's Hospital in New York City.

The temptation to stray from my assigned topic, to deal with the Alabama and European successes of Sims, is provocative, but they are tales well told. The Alabama years by your own Dr. Buford Word, at Boston, in 1964, while his Continental exploits in various European hospitals were carefully retraced by Dr. C. Lee Buxton. in New York, in 1963.



James Marion Sims

Little did Sims dream, on that summer day in Montgomery, Alabama, as he prepared to re-examine the slave girl, Lucy, that he was launching himself on a national and international career as a gynecologic surgeon, or that he was to raise gynecology from a virtually nonexistent to a respected surgical

specialty. Nor could he have been aware that his small, primitive, eight bed hospital in Montgomery, would be the forerunner of America's first Woman's Hospital.

James Marion Sims, arrived in New York City in the early autumn of 1853, in a last desperate attempt to regain his former health. For the past three years, he had been unable to practice medicine and even now was considerably emaciated by his old malady, a chronic type of colitis. Only in New York, so he said, had he found relief from his infirmity.

Sims was still a sick man, nervous, irritable and worried about beginning a new surgical career in a strange city, among an alien Yankee society.

Feeling that death would soon overtake him, he had previously announced his discovery of the cure of vesico-vaginal fistula by sending his manuscript to Isaac Hays, editor of the American Journal of Medical Science.

Sims purchased a home between 28th and 29th streets on Madison Avenue. The house was on the outskirts of the growing city, but it was in keeping with his financial status, which in the light of a growing family and his own precarious health and lack of income, precluded any other arrangement.

Thus, we find him in New York, in 1853, untouched as yet by fame, despite his masterly article on vesico-vaginal fistula. He was a poverty stricken, ambitious man seeking an opportunity to display his operative skill, motivated by the desire to be a "benefactor to his race, to relieve suffering humanity and to advance the cause of science." He was a man filled with scientific zeal and "lofty selflessness." His confidence in his surgical skill was the confidence that is born of experience. He was self reliant, prophetic in reasoning, direct in action and intensely human.

When Sims left Alabama, to become a permanent resident of New York City, the idea of establishing a Woman's Hospital was surely in a nebulous state, but as his health improved, we soon find him confiding his plan of establishing a special hospital for women. His confidants were Dr. John Wakefield Francis and Dr. Valentine Mott.

From the vantage point of 1965, one might say that the founding of the Woman's Hospital was due in a great measure to the progressive, enlightened and social awareness of a few devoted women, a few physicians, a few wealthy men, and the chance acquaintance with Henry Luther Stuart. Mr. Stuart, had been a former engineer, former newspaper editor, free lance writer, and Scotsman from the State of Vermont, and of course, Sims.

On May 4, 1855, the Woman's Hospital opened its doors in a rented building on Madison Avenue, between 28th and 29th streets. The annual rent was $1,500. There were between 30 and 40 available beds. The new hospital was a success from the beginning. Sims was operating daily. The Woman's Hospital ledger reveals 11 operations for vesico-vaginal fistula operated upon in the first 13 days of the hospital's existence.

The chief features were the proper positioning of the patient in Sims position, the vaginal speculum with proper lighting reflected from a mirror, and most important, the silver wire suture material. Thus, the uniform and consistent success attained by Sims, demonstrated that when the method of operating was properly applied, primary union became the rule and not the exception.

Sims great achievement was not which is so commonly, but erroneously attributed to him, namely, priority in the cure of vesico-vaginal fistula, but rather that of perfecting and popularizing a technique which was simple in principle and more universally applicable than any previously devised.

It soon became apparent that Sims could not do all the work single-handed, and an assistant became a necessity. In the same year (1855) Thomas Addis Emmet was appointed Assistant Surgeon to the Woman's Hospital, with a salary of $500 a year. He

refused the salary on the ground that the hospital needed it more than he did. After assisting Dr. Sims daily until fully acquainted with his technique, Emmet was soon performing a good share of the operations at the hospital, besides attending to all the case histories, recording the operations performed in an appropriate ledger. Sims had neither the time, inclination or temperament to bother with statistics. These early case histories, written in longhand and illustrated by colored drawings, are at present on display at the Woman's Hospital. As has been stated, the recorder and artist was Thomas Addis Emmet.

The relationship between Sims and Emmet had been described as that of a tolerant father toward a son. Emmet was completely captivated by Sims and years later stated that, "Dr. Sims was by nature a surgeon and one of the most dexterous operators I ever witnessed. He was bold and self reliant, never at a loss, and his ingenuity was unequalled. He was in no sense a plodder, for his mind and body were always too restless and active. He was so fertile in resource when I first knew him that he perfected scarcely a tithe of the brilliant conceptions passing constantly through his mind, and it was impossible to see him perform the most simple operation without learning something new."

The primary motive in opening Woman's Hospital, was to devote it solely to the cure of vesico-vaginal fistula by the Sims technique. The treatment of other diseases of women was an afterthought, and as the two doctors entered upon this added field, Emmet possessed as accurate a knowledge as Sims of what little was then known of these gynecological entities.

That Sims was the teacher in this country was undisputed. He was now a busy practitioner, with a large and profitable consulting and surgical practice, who nevertheless, found time to publish his articles and to lecture on gynecological topics.

In February 1854, Sims published a case report on a vesico-vaginal fistula cured by his silver wire technique. Three years later, on November 18, 1857, he was chosen to deliver the Anniversary Oration at the New York Academy of Medicine. Sims eloquently described the various uses of silver wire as a suture material, as contrasted with silk or thread which was then in general use. He described his success using silver wire in vesico-vaginal fistula; in old third degree lacerations of the pelvic floor; in cases where plastic surgery of the face was necessary; in harelip and wounds of the scalp; in amputation of breast or amputation of the thigh or leg.

He told of the number of patients thus treated and the number who healed by primary union. He advocated tying the pedicle of an ovarian cyst by silver wire and dropping it back into the abdomen. He spoke of suturing the large bowel with fine silver wire sutures in gunshot wounds of that organ. He closed his oration with a glowing picture of the new Woman's Hospital to be, with its large and well appointed staff.

For some time it was evident that the capacity of the original hospital was inadequate for the needs of the growing field of the surgical approach to gynecological problems.

The land on which the new Woman's Hospital was to be built belonged to New York City. Situated between 49th and 50th Streets, east of Park Avenue, it comprised a whole city block and is now the present site of the Hotel Waldorf-Astoria.

Sims failed to state that it was by his own great efforts and zeal that this new institution was on the way to becoming a reality.

In 1867, the Wetmore Pavilion of the new Woman's Hospital was opened. It had 68 available beds. It is of historical interest that 23 beds on the fourth floor were free; that 15 beds on the third floor cost the patient $6 a week; that 14 beds on the second floor or private wards, with separate rooms, were available for $15 a week. All medical and surgical services were gratuitous!!

During the year, 264 patients had been admitted. There were 15 deaths during the

year. Five of these occurred as a result of ovariotomy. In the outpatient department 2,050 patients had been treated by physicians in attendance.

In the following year 1868, appeared Sims' textbook, entitled, "Clinical Notes on Uterine Surgery." It was hailed as a valuable text by many, sharply criticized by others. Among its important chapters was one on the treatment of sterility. "To treat sterility, we must ascertain if the spermatozoa go into the cervix uteri Secretion from the cervix uteri are to be examined 24 to 36 hours post-coitum, and if the spermatozoa are alive, the patient is cured." In England, this test is know today as the Sims test. In America, it is called the Hunner test.

Sims was severely criticized for his frankness about the treatment of sterility. He was many years ahead of his contemporaries in advocating the use of the microscope as an aid in the diagnosis and treatment of sterility. His proposal for artificial insemination roused the Medical Times and Gazette of London to express, "An unfeigned regret that Dr. Marion Sims had thought proper to found an odious style of practice on such methods. Better let ancient families become extinct than keep up the succession by such means."

It may be stated that this book of Sims revolutionized modern gynecological practice. And while this statement applies with more force in this country, where new ideas and bold measures are more readily accepted, it was true also to a large extent in Europe, where, chiefly in England and France, many able and dexterous surgeons were vying with each other in widening the path traced for them by Marion Sims.

I have no intention of giving a complete list of Marion Sims' contributions to gynecological surgery. However, I have selected a list from the 1879 index of Emmet's Textbook to denote somewhat the extensive gynecological knowledge of Sims. Emmet's index lists the following operations: Sims, on Vesico-Vaginal Fistula; Sims, on Cystocele; Sims, on Retention Catheter; Sims, on Procidentia; Sims, on Silver Wire Sutures; Sims, on Amputation of the Cervix; Sims, on Repair of the Cervix; Sims, on Ovariotomy; Sims, on Enucleation of Fibroids; Sims, on Dysmenorrhea; Sims, on Repair of Perineum, and finally, Sims, on Epithelioma of the Cervix.

In 1877, the Baldwin Pavilion, designed to accommodate 69 patients was opened. A new era had dawned. Listerism had arrived at the Woman's Hospital. Sims operated under the carbolic spray, instruments, sheets and towels were dipped in 1:20 carbolic solution. Three cottages were erected next to the pavilion to house all "serious cases." It was here that operations were performed and patients were returned to the main building only when the move was considered "safe," presumably when their temperature reached normal. This method reduced the incidence of wound infection and appreciably reduced the dreaded surgical aftermath, septicemia and peritonitis.

The scientific aura of the Woman's Hospital was further enhanced by the appointment of William Henry Welch, as pathologist. After serving for three years, he left to become pathologist at Bellevue and later became famous at Johns Hopkins University.

Progressive ideas of enlarging the scope of Woman's Hospital were constantly brought up at the Annual Meetings. Both board members and outside speakers stressed the fact that Sims and Emmet had long since abandoned the original idea of a hospital devoted exclusively to the treatment of vesico-vaginal fistula. They invisioned, instead, a hospital for the treatment of all gynecological diseases, curable or incurable, and hoped that the Woman's Hospital would lead the field as a testing ground in the new era of gynecology, inaugurated by Recamier of France, Simon in Germany, Simpson and Keith in Scotland, Sims, Emmet and Atlee brothers in America.

Here at Woman's Hospital, over the past 100 years, have gathered literally thousands

of visiting gynecologists and staff physicians destined to become leaders in their profession. Here, they witness operations from which womankind has benefited enormously.

At the Woman's Hospital, surgical removal of ovarian cysts by abdominal invasion, hysterectomy for fibroids and various vaginal plastic repairs with amputation of the cervix were all in a day's work through trial and error and research, of course, various techniques were introduced, tested, improved upon, and occasionally entirely abandoned.

Sims was that gallant figure who strode like a giant through the sick rooms and makeshift surgical amphitheatres of Europe, and moved with ease in the Court of Louis Napoleon and the Empress Eugenie. He retained throughout his life the cordiality and courtly manners of his southern upbringing. His buoyant temperament and ready smile were splendid assets, and his quick mind had a resource for any emergency.

Among the younger men in medicine in this country, he became their leader. Physicians were deeply impressed by his textbook on uterine surgery. They flocked to hear him speak and watch him operate. They found themselves enchanted by his dashing enthusiasm, his boyish impulsiveness, and accessibility.

Sims had his detractors, and one wonders if it were not due to some extent to his superior attitude towards surgery in all fields. He could, on occasion, annoy his professional brothers by making extravagant and tactless statements, and many hated him with the vindictiveness which the dull always show towards a genius beyond their comprehension.

Not long after Sims returned to New York, in 1871, his interest in cancer brought him into conflict with the kind of ignorance and superstition that had confronted other pioneers in the field of surgery.

In 1874, in the midst of the conservative reign of Queen Victoria, the Board of Lady Supervisors of the Woman's Hospital passed a by-law whereby only 15 visitors could witness an operation. The board also issued orders that no more "cancer patients" were to be admitted to the hospital, and if perchance one gained entrance, the house surgeon was to d i s c h a r g e her immediately. These reactionary and arbitrary rules, born of ignorance and prejudice, aroused the ire of Dr. Sims. He emphatically, perhaps undiplomatically, voiced his opposition. He announced that unless the two rules were repealed at the next Board Meeting. he would resign from the hospital. The Ladies Board made it official on December 22, 1874. Sims' resignation was accepted.

If the popularity of Marion Sims was temporarily at low ebb at the Woman's Hospital, it was not true throughout the medical world, for in 1875, he was elected President of the American Medical Association. Marion Sims was reinstated at the Woman's Hospital in 1880, and in the same year was again honored by being elected President of the American Gynecological Society.

As President of this select Society, Sims chose as his address an unpopular subject, which was that the Executive Board should increase the membership of the society so that it could become a real democratic organization of representative groups of gynecologists. Needless to say, the plea went unheeded. Eventually new societies became a necessity.

With Sims departure from the Woman's Hospital, he developed new interests that were to shape the remaining years of his life. Sims had been extremely interested in the subject of uterine malignancy since 1855. In 1879, he published his Treatise on Epithelioma, or Cancer of the Cervix. In this lucid article, Sims outlined his own surgical treatment for this lesion.

In 1883, the subject of the treatment of cancer led John J. Astor, influenced by his wife and her cousin, Mrs. Elizabeth Cullen, to offer $150,000 for a separate pavilion at the

Woman's Hospital, to be used exclusively for cancer treatment. The offer was refused. No valid reason was stated.

Sims' dedication to the search for an effective cancer treatment, however, had become known to a circle of his friends, wealthy and powerful enough to do something about it. In September 1883, Sims willingly submitted a statement to be used in mustering support for a Cancer Hospital. To quote in part:

> "A Cancer Hospital is one of the great needs of the day, and it must be built . . . Let its promoters procure a site, build a hospital and organize a board of medical counsellers at once . . . Doubtful points of practice can be settled in the wards of a great hospital . . . I would take knowledge wherever it can be found . . . I would invite any man who claimed to have a specific to come and try his remedies . . . It is time we turned a listening ear to the cries of humanity. The subject of cancer is too large and its interest too great to be lodged in a pavilion subsidiary to any other hospital, whether special or great."
>
> Signed: J. Marion Sims,
> September 23rd, 1883

Sims' letter received widespread publicity in the New York newspaper, and led to a definitive meeting at Mrs. Elizabeth Cullen's home at 261 Fifth Avenue, on February 7, 1884. The cornerstone was laid for the Astor Pavilion for Women, on May 21, 1887, and formally opened on December 6, 1887. Unfortunately Dr. Sims did not live to see it in operation.

It seems possible that without the inspiration of Sims ideas and effort along these lines, the New York Cancer Hospital, now the Memorial Hospital, might not have been founded.

With Sims came the revolution which upset the conservative "do little methods" and opened wide the field of active, radical, scientific treatment by surgical means of diseases which formerly were merely palliated or left unrelieved.

In what proved to be Sims' valedictory address at the New York Academy of Medicine in 1880, Sims made a fervid plea for the immediate exploration of the abdomen for extra-uterine pregnancy, or in suspected perforation of the bowel by gunshot wounds. He also advocated abdominal operation for the "extirpation" of the cancerous uterus or bleeding fibroids.

In closing, he said, "Rest assured that the day will come, and in the not too distant future, when an accurate diagnosis in such cases (intra-abdominal injuries and diseases) followed by prompt action will save lives that otherwise quickly ebb away."

In the discussion which followed, local surgeons decided his ideas were too radical and not practical. However, four years later, Dr. William T. Bull, of New York, reported a successful case of intestinal suture for gunshot wounds of the abdomen. From that date the operation has been frequently and successfully performed.

Sims was about to sail to Rome, in November 1883, having engaged passage, when apparently in robust health, he was seized with dyspnea at three o'clock on the morning of November 13, 1883. When his son, Dr. Harry Marion Sims, reached his bedside, he expired without a word. He was in the 71st year of his life.

A study of Sims would be incomplete without a word of Mrs. Theresa Sims. Her

influence on him can best be summarized by quoting the tribute paid to her by Dr. Thomas Addis Emmet. Emmet recalls that Eliza Theresa Sims continued to be the sweetheart of his youth and his helpmate through a long life. "I have heard him state that he would have accomplished nothing without the aid and advice of his wife. She certainly devoted her life to him, and I never saw a person more dependent on another than he upon her. When I first knew them, and he was in bad health, she always prepared with her own hands every article of food he needed. She watched over him with the singleness of purpose only equalled in the care of a mother for her offspring. For his impulsive nature, her placid disposition was as essential as the flywheel to an engine, and he has said that through her whole life, he never had to regret following her advice."

James Marion Sims was the founder of The Woman's Hospital in the State of New York, and certainly one of the founders of modern gynecology, who by the force of his own genius, indomitable will and untiring energy, invaded the unexplored field of the operative phase of his specialty.

He elaborated his own system of pathology, invented new instruments to meet new requirements and covered the whole range of gynecological surgery in the pre and post antiseptic era. Characteristic of all pioneers who ventured into unexplored fields, Marion Sims was a bold though careful operator with an imaginative and intuitive mind and possessed an unusual technical skill. Although handicapped during most of his lifetime by difficulties and dangers attending surgical maneuvers prior to the g e n e r a l use of anaesthesia and the prevailing lack of asepsis, his surgical feats remain to this day outstanding.

BIBLIOGRAPHY

Bender, George A., Extract from A History of Medicine In Pictures, Parke, Davis & Co., 1963.

Buxton, C. Lee, J. Marion Sims' European Experiences, Reprinted from Journal of American College of Obstetricians and Gynecologists, Vol. 22, No. 4, p. 543, October 1963.

Considine, Bob, That Many May Live, Memorial Center for Cancer and Allied Diseases, New York, MCMLIX.

Emmet, Thomas Addis, Vesico-Vaginal Fistula, William Wood & Co., New York, 1868.

Harris, Seale, Woman's Surgeon, Macmillan Company, New York, New York, 1950.

Heaton, Claude E., The Influence of J. Marion Sims on Gynecology, Reprint from Bulletin of New York Academy of Medicine, Second Series, Vol. 32, No. 9, September 1956.

Marr, James Pratt, James Marion Sims, Privately Printed, February 1949.

Marr, James Pratt, Pioneer Surgeons of the Woman's Hospital, F. A. Davis Company, 1957.

Sims, J. Marion, Vesico-Vaginal Fistula, Reprint, American Journal Medical Science, January 1852.

Sims, J. Marion, The Story Of My Life, D. Appleton & Co., New York, 1885.

No One Knows Like The Maker

When physicians encounter an adverse drug reaction it is not uncommon for them to write to the distributor of the drug, possibly in the form of a complaint or as a request for information on similar experience. Reports are often transmitted through the detail man. No one knows as much about marketing experience with a drug as its distributor.—Ralph G. Smith, M. D., in *Journal of New Drugs*, (6:66), January-February 1966.

Pancreatitis: Medical And Surgical Management

By James R. Shamblin, M. D.

General Surgical Staff
Druid City Hospital
Tuscaloosa, Alabama

INTRODUCTION

Pancreatitis is one of the less common causes of the so-called "acute abdomen." It is rarely seen in children and occurs most often in adult males. As defined by Gambill, acute pancreatitis refers to the "painful seizure and its attendant symptoms and to the pathophysiologic processes in the pancreas and other organs and structures affected by the disease." Chronic relapsing pancreatitis is the inflammatory and destructive process in the pancreas with *recurrent* episodes of acute pain and associated symptoms.

ETIOLOGY

Pancreatitis may be arbitrarily classified as follows:

I. Gallstone pancreatitis
II. Alcoholic pancreatitis
III. Specific varieties
 A. with hyperparathyroidism
 B. with familial hyperlipemia
 C. hereditary
 D. postoperative
 E. mumps
IV. Idiopathic pancreatitis

In a collected series of cases, biliary tract disease was present in 14-94 per cent of patients with pancreatitis.[5] Gallstones were considered the causative agent in 168 of 371 cases from a university hospital. The "common channel" theory of pancreatitis originated in a patient of Opie's who had a stone lodged at the ampulla. Opie also reported another patient who had a common duct stone causing impingement on the duct of Wirsung. Gallstone pancreatitis tends to recur as long as the stones are present, but rarely results in a fibrotic, calcified gland and the complications thereof. It is this group of patients who have the most satisfactory response to surgery.

Alcoholic pancreatitis, on the other hand, tends to follow a somewhat different course. It occurs usually in young men who have been heavy drinkers for about eight-ten years. They are frequently inebriated when first seen. The clinical picture may present evidence of pancreatitis, gastritis, and cirrhosis. Approximately one-half of the patients die by 45 years of age from pancreatic disease, gastrointestinal hemorrhage, liver disease, or vascular occlusion. Their attacks are typically recurrent, and calcification and fibrosis of the gland are common. They are then plagued with constant pain, alcohol and opiate addiction, and deficiencies of the pancreatic endocrine and exocrine function.

There have been 15 cases reported of pancreatitis associated with hyperparathyroidism. Forty cases of pancreatitis and hyperlipemia have also been reported. An hereditary form of pancreatitis, occurring principally in young females, and associated with calculi in the larger pancreatic ducts and an increase in urinary lysine excretion has been studied at the Mayo Clinic. Postoperative

pancreatitis occurs not infrequently after operations on the biliary tract, stomach, duodenum, or pancreas. Abdominal pain and elevated serum amylase occur in some patients with epidemic parotitis. No etiologic agent could be found in 88 of 371 cases of pancreatitis.[1]

PATHOLOGY

Acute pancreatitis usually occurs either as interstitial inflammation or hemorrhagic and necrotizing inflammation.

Interstitial pancreatitis occurs mainly in young adults and the clinical picture tends to be mild. The pancreas is edematous, firm, and whiter than normal. Microscopically there is edema of the pancreas and surrounding tissues with infiltration of neutrophils. Small areas of fat necrosis may be present.

Acute hemorrhagic pancreatitis is thought to be caused by the release into the pancreatic substance of activated trypsin and lipase, whether due to obstruction of the pancreatic duct or other causes. The clinical picture is more severe and death is not infrequent. The pancreas is enlarged and firm with areas of necrosis. Hemorrhage and gangrene may involve the gland and surrounding structures. Fat necrosis may be widespread. Microscopically, the areas of fat necrosis are surrounded by hyperemia and leukocytic infiltration. Blood vessels may be necrotic and thrombosed. Abscesses, sinus tracts, and pseudo-cysts may be seen in cases of long duration.

In chronic relapsing pancreatitis, the pancreas is found to be atrophied and indurated. Necrosis and mucopurulent exudate may be present. The ducts are sometimes dilated. Microscopically, interstitial fibrosis, necrosis, atrophy, and lymphocytic infiltration are seen.

CLINICAL MANIFESTATIONS

Pancreatitis most commonly occurs in men during the third and fourth decade. Sudden, catastrophic pain may be the outstanding symptom. Although it may vary in intensity, it is usually steady, lasting for days, beginning in the epigastrium and radiating to the back, diffusely over the abdomen, or to the thorax. It is commonly precipitated by alcohol or a large meal. Opiates provide only temporary relief. Nausea and vomiting, abdominal distention and bloating, weakness, fever, and low-grade jaundice may occur. The patient prefers the flexed position with pressure over the abdomen, but if peritonitis has occurred, he may lie supine and motionless. Direct and rebound tenderness may be present. If retroperitoneal hemorrhage has occurred, the Grey-Turner sign, a bluish discoloration in the flanks, may be present.

Asymptomatic pancreatitis must also occur as evidenced by the autopsy findings of calcification and fibrosis of the pancreas in patients with no history compatible with pancreatitis.

The acute attack may subside never to recur again, but a great percentage of patients experience recurrent episodes. Between these episodes, the patient may be asymptomatic, but he *may* have constant pain and symptoms of pancreatic insufficiency.

LABORATORY AND RADIOLOGIC FINDINGS IN ACUTE ATTACK

Mild hypochromic anemia and leukocytosis are frequent. However, the patient may have an increased hematocrit in severe cases with a markedly lowered total blood volume due to extravasation of plasma and whole blood into the inflamed tissues and peritoneal cavity. Gastrointestinal hemorrhage may also occur. There may be a transient glycosuria and increase in the fasting blood sugar. Serum amylase levels of greater than 250 Smogyi units are present early in many cases, but may decrease after 48 hours even with continuing symptoms. Serum lipase values rise slowly to 72 Cherry-Crandall units in about 50 per cent of cases, then fall slowly over several days. A two-hour urinary amylase may remain elevated even after

serum amylase has returned toward normal.[1] Of some prognostic significance is the serum calcium level; values less than 7 mg per cent are found frequently in patients who die during the acute episode. Elevated amylase values can be found in perforated peptic ulcer, intestinal obstruction, perforation of small intestine, administration of opiates, ruptured ectopic pregnancy, bronchogenic carcinoma, mumps, and renal insufficiency.[1]

DIFFERENTIAL DIAGNOSIS

The differential diagnosis of the acute attack should include free perforation of a viscus, acute intestinal obstruction, myocardial infarction, biliary colic, renal colic, and porphyria. With a perforated viscus, free air may be seen under the diaphragm, the tenderness in the epigastrium may quickly proceed to boardlike rigidity, and the serum amylase and lipase are usually lower than with pancreatitis. The pain of myocardial infarction frequently radiates to the left shoulder and arm, the serum enzymes are not elevated, and the transaminase is high. Electrocardiographic changes can be present with pancreatitis, however. The pain of intestinal obstruction is usually colicky with relative comfort between pains and the X-ray may be characteristic. Biliary and renal colic may have typical radiation. The X-ray findings of acute pancreatitis may show a dilated, isolated loop of small intestine in the upper abdomen, generalized ileus, duodenal obstruction, a non-functioning gallbladder, or may be entirely normal.

CLINICAL AND LABORATORY FINDINGS IN CHRONIC PHASE

Approximately 20 per cent of patients experiencing recurrent pancreatitis will develop signs and symptoms of pancreatic endocrine and exocrine insufficiency. Permanent diabetes occurs which may be hard to control, especially in the alcoholic. Inanition and chronic pain are common. Increased fecal fat and nitrogenous products are excreted, and these are measured by putting the patient on a measured intake. Analysis of duodenal contents after administration of secretin or Mecholyl may give significant results in up to 50 per cent of cases. However, this test may provoke an acute attack. The X-ray typically shows diffuse pancreatic calcification. Pancreatic cysts may be seen on a flat plate or during an upper gastrointestinal series.

MEDICAL TREATMENT

Medical treatment of acute pancreatitis has taken the place of surgical treatment in the uncomplicated case because of high surgical mortality and low mortality following medical management. In the acute stage the first consideration in medical management should be the treatment of shock and pre-shock by the use of serum albumin, other plasma expanders, and whole blood. Death in pancreatitis is due primarily to circulatory failure. The vital signs, hematocrit, and blood volume should be followed carefully. The patient should be confined to bed in the position of maximum comfort. Control of pain is difficult, but Demerol® is usually the drug of choice. Similar relief of pain can be achieved by intravenous procaine. Splanchnic, paravertebral, or epidural nerve block may be necessary. Nausea, vomiting, and distention are controlled by a Levine or Miller-Abbott tube. Anti-cholinergics are given to reduce pancreatic secretion. Nitrites, magnesium compounds, papaverine, and aminophylline are thought by some to promote drainage of the pancreaticobiliary tree by relaxation of the sphincter of Oddi. Sedation in the form of barbiturates or tranquilizers is given in moderation. Fluid and electrolyte balance must be carefully adjusted with special attention to the level of serum calcium. If hyperglycemia is present, it may be treated with appropriate doses of insulin. Antibiotics are given only if fever or other evidence of bacterial infection is present. Irradiation and steroid therapy are reserved for the refractory cases. Recent studies have suggested that the trypsin inhibitor Trasylol should be used in all severe cases.

There are several supportive and preven-

tive measures that can be taken in the chronic phase. Control of pain is particularly difficult because of the tendency towards addiction. For this reason more patients are being considered for total pancreatectomy on the basis of intractable pain alone. The patients must avoid alcohol. The diet should be adjusted to individual tolerance, but should consist of multiple, small feedings of a high caloric, high carbohydrate, moderate fat, 100-120 gm. protein type with oral pancreatic enzyme replacement if necessary. Control of the diabetes requires insulin in most instances. Because of the emotional factors that are thought by some to play a part in this disease, avoidance of physical and mental stress is accomplished by "sedation, suggestion, reassurance, and psychotherapy."[2]

SURGICAL TREATMENT

Surgery in the acute phase is now contraindicated except when the diagnosis is not clear. If the abdomen is opened and acute pancreatitis is found, the treatment in most instances is immediate closure with or without drainage of the peritoneal cavity. Drainage of the biliary tract is indicated when it is diseased. Surgery for evacuation of an abscess or drainage of a pseudocyst may be necessary at some time during the acute episode, but is best deferred until the signs of an acute abdomen have subsided and the serum enzymes have returned to normal.

It is in the chronic phase that surgery is sometimes the treatment of choice. If gallbladder disease is present, a cholecystectomy with or without choledochostomy is performed. Doubilet and Mulholland have recently advised sphincterotomy if spasm or fibrosis of the ampullary region is present. They claim as high as 90 per cent *improvement* in selected cases.[3] Fatal acute pancreatitis has occurred following this operation, however. If pancreatic calculi are present, pancreatolithotomy may be done. Much work has been done recently on procedures to anastomose the duct of Wirsung to the intestinal tract by resection of the tail of the pancreas and anastomosis of the remainder of the gland to the jejunum, either directly or by a Roux en Y segment.[4] Unfortunately this procedure is not always successful because there may be multiple obstructions within the remaining duct. In an attempt to circumvent this problem, the pancreatic duct has been longitudinally divided in its entirety and side-to-side anastomosis with the jejunum has been performed. This has been used on only a limited number of patients. Total pancreatectomy is usually reserved for patients with intractable pain in which other surgical procedures were unsuccessful.[3]

SUMMARY

Pancreatitis is a disease of multiple etiology. The clinical course is fairly typical and laboratory results, although not entirely specific, are very helpful in diagnosis. The objectives of medical management are (1) palliation and termination of the acute attack, (2) prevention of recurrences, and (3) control of the symptoms of pancreatic insufficiency. Surgical treatment is reserved for complications of the disease.

BIBLIOGRAPHY

1. Gambill, E. E.: Acute and chronic relapsing pancreatitis. Proc. Staff Meet. Mayo Clin. 35: 67, 1960.

2. Bachrach, W. H. and M. I. Grossman: The medical management of acute and chronic pancreatitis. Med. Clin. N. America. 43: 1101, 1959.

3. Frieden, J. H.: Surgical therapy of acute and chronic pancreatitis. Med. Clin. N. America. 43: 1119, 1959.

4. Peustow, C. B. and W. J. Gillesby: Retrograde surgical drainage of the pancreas for chronic relapsing pancreatitis. A. M. A. Arch. Surg. 76: 898, 1958.

5. Stefanine, P.: M. Ermini and M. Carboni: Diagnosis and management of acute pancreatitis. Am. J. Surg. 110: 866, 1965.

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1. Barowsky, H.; Greene, L., and Paulo, D.: Cinegastroscopic Observations on the Effect of Anticholinergic and Related Drugs on Gastric and Pyloric Motor Activity, Amer. J. Dig. Dis. *10*:506-513 (June) 1965.

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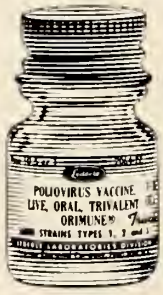


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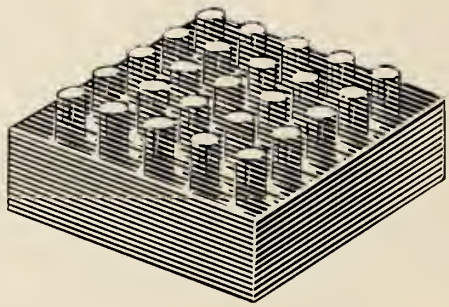


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*Rosenthal, S. R., Nikurs, L., Yordy, E., and Williams, W.: Scientific Exhibit Presented at the Annual Meeting of the National Tuberculosis Association, Chicago, Illinois, May 30-June 2, 1965.

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OBITUARIES

DR. J. RAYFORD HODGES, SR.

Dr. J. Rayford Hodges, Sr., 76, of Scottsboro, a physician and surgeon, died of a heart attack on May 4.

He was a life-long resident of Jackson County. Dr. Hodges was a graduate of Jacksonville State College and received his medical degree from the University of Alabama in 1915 when the school was in Mobile. He was a veteran of World War I, serving two years in Europe with the U. S. Army. A Medical Corps captain, he was in the Fourth Division.

Dr. Hodges became a member of the Fifty Year Club in 1965. He was a co-founder of Scottsboro's first hospital in 1924 with the late Dr. E. G. Nye.

Hodges Hospital remained open until 1958 when it became the Hodges Clinic.

Dr. Hodges practiced with a son, Dr. Durwood Hodges, who joined him in 1955.

He was a member of the Medical Association of the State of Alabama and the American Medical Association.

Survivors include his wife, Mrs. Jennie McGahey Hodges; two sons, Rayford Hodges, Jr., and Dr. Durwood Hodges, all of Scottsboro; a daughter, Mrs. Tom Fowler of Birmingham; two sisters, Miss Ruthis Hodges of Scottsboro and Mrs. P. D. Wilson of Birmingham; and seven grandchildren.

DR. CLARENCE GLADIN FARISH

Dr. Clarence Gladin Farish, 57, physician in Moulton for 18 years died of a heart attack on April 4.

Dr. Farish was a native of Mt. Pleasant in Monroe County. He attended Auburn University and studied medicine at Tulane University. He graduated in 1933 with a doctor of medicine degree. He served his two-year internship at Mobile Hospital.

He served as an officer in the Civilian Conservation Corps during the 1930's. In 1939 he set up a private practice in Moulton with three other physicians. A year and a half later, he enlisted in the U. S. Army as a medical doctor and served until December, 1945. He returned to Moulton where he once again practiced medicine.

Dr. Farish was a member and past president of the Lawrence County Medical Society. He was a former member of his County Board of Censors. He served as Lawrence County coroner for three years.

He was a member of the Medical Association of the State of Alabama and the American Medical Association.

Survivors include his wife, Mrs. Tommie Farish; a son, George Farish of Atlanta, Georgia; one half-sister, Mrs. Fred D. Sawyers, Birmingham, Michigan; and an uncle, George Carleton, Grove Hill.

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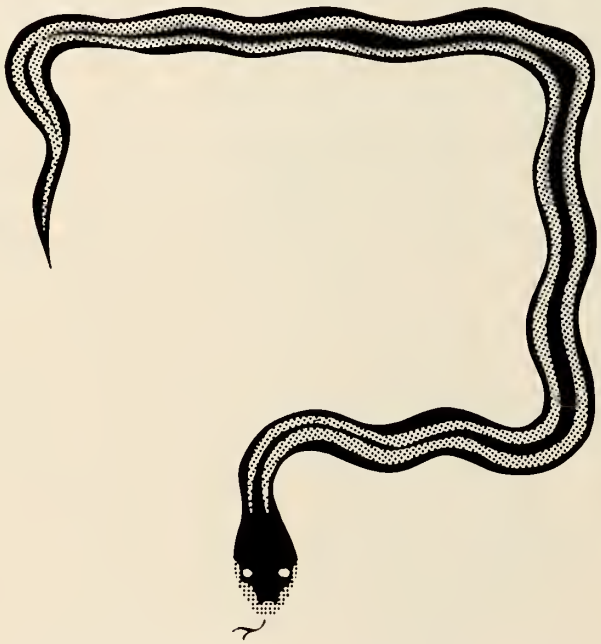
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1. Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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Neonatal Resuscitation

By

Chester W. White, Jr., M. D.

and

Rodolfo R. Allarde, M. D.

Department of Anesthesia

University of Alabama Medical Center

Birmingham, Alabama

Since the principles and techniques of infant resuscitation are well-documented and authorities agree essentially on all the salient features, it is remarkable that neither are rational methods consistently applied nor are the established current conceptions of the problem universally recognized. Because of this apparent delay in the general adoption of optimal procedures, it is appropriate to review this subject for the physicians of Alabama. Neonatal differs from adult resuscitation only in technical particulars, so that cardinal features of both may be summarized in a comprehensive statement, to wit: ASSURE PULMONARY VENTILATION AND SUPPORT CARDIOVASCULAR FUNCTION TO THE EXTENT INDICATED, BY THE MOST CONSERVATIVE EFFECTIVE MEANS, IN THE SHORTEST POSSIBLE TIME. If one is able to implement understandingly all the injunctions of this formula, he is a competent resuscitator. A detailed analysis of this epitome is a sound basis for both theoretical and practical exposition of the subject.

The phrase "in the shortest possible time" is a good starting point, and it encompasses many things not directly stated. To begin with, the actual moment of birth is purely fortuitous and its relationship to post-partum events has no positive interpretation. The correlation of areflexia, apnea, or cyanosis with the time of birth is convenient and customary[1], but it is an extremely restricted criterion of infant condition[2]. At the same time it is apparent that the longer such period extends, the more grave is the situation. The

(Continued on Page 1041)

In the April, 1966, issue of this Journal, William A. Walker, M. D., presented a well-organized article "Resuscitation of the Newborn." With this as an introduction, your committee thought that a more detailed approach from the viewpoint of another specialist would now be appropriate. The reader will note that the approach of both essayists is coincident, and that the order of procedure, and general recommendations, and cautions are almost identical. This occurred without prior knowledge or communication among them; and all have quite different backgrounds, leaving no doubt of unanimity of thought among individuals with special competence in this field.

Gilder Wideman, M. D.
Chairman, Committee on
Maternal and Child Health

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(Continued from Page 1039)

duration of relative hypoxia *in utero*, if there were evidence of it, must also be considered in plausible evaluation. The obstacle which must be overcome is the total effect on the infant of an undetermined degree of hypoxia, usually of uncertain duration[3]; not only the total hypoxic insult but also the particular infant's tolerance for it is unknown. The former belief that the neonate has just emerged from a chronic environment of relative hypoxia is no longer tenable[4]; and although infants can tolerate lack of oxygen better than the adult[5], this maxim does not warrant an apathetic approach in the clinic. Guidelines should therefore be set to assure the logical and timely succession of suitable resuscitative measures; it must be understood, however, that such guidelines are arbitrary, recommended to avert on one hand overly aggressive or meddlesome treatment[6] and on the other an excess of moderation. With reservation, it may be suggested that ventilation and circulation must be supported effectively within three minutes after birth under average circumstances. This interval is by no means sacred; it represents neither an ideal of achievement for the operator nor a categorical standard of tolerance for the neonate. Furthermore, the birth of a limp and cyanotic infant following a known period of intrapartum distress often requires immediate implementation of a maximal effort[7].

Another function of time which enters into resuscitation is the selection of specific intervals for assessment of neonatal status. This becomes a continuous almost unconscious procedure for those experienced in management of the newborn and does not require interruption of indicated therapy; it is the *sine qua non* to identification of " . . . the most conservative effective means." A number of suitable standards for evaluation of the newborn have been devised, but widespread endorsement of the timed Apgar score (routinely recorded at one and five minutes after birth) has given it great validity, established its prognostic value, and provided an unchanging basis for the objective comparison of infants born at different times or in different institutions[8]. Factors in the scoring system, which should be strictly adhered to, are detailed in Table I; further discussion of

TABLE 1

SIGN	0	1	2
HEART RATE	ABSENT	SLOW (BELOW 100)	OVER 100
RESPIRATORY EFFORT	ABSENT	SLOW, IRREGULAR	GOOD, CRYING
MUSCLE TONE	FLACCID	SOME FLEXION OF EXTREMITIES	ACTIVE MOTION
REFLEX IRRITABILITY	NO RESPONSE	CRY	VIGOROUS CRY
COLOR	BLUE, PALE	BODY PINK, EXTREMITIES BLUE	COMPLETELY PINK

Apgar Scoring Chart

the score itself is hardly profitable, since everyone is familiar with it[1]. The point to be stressed is that IMPROVEMENT OF ANY OR ALL FACTORS IN THIS SCORE INDICATES THAT THE APPLIED MEANS OF RESUSCITATION ARE EFFECTIVE AND SHOULD NOT, THEREFORE, BE ABANDONED IN FAVOR OF MORE AGGRESSIVE TACTICS. Since all functions observed in scoring are physiologically related, improvement is likely to be manifested by an increase of three or four points in most cases. More adequate cardiac function, for example, is likely to be associated with improvement in color, muscle tone, and/or reflex responsiveness.

Another phrase in the epitome which is still peripheral to actual procedure is, "to the extent indicated." The utilization of measures or devices in resuscitation which are not positively indicated is not just meddlesome, it obstructs appropriate action as well and has great potential for causing injury. An infant's active resistance to insertion of an oropharyngeal airway or endotracheal tube, for instance, is clear evidence (1) that he has been improperly evaluated, and (2) that the instrumentation is not

(Continued on Page 1042)

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needed; only harm can result from such unnecessary manipulation. This and similar ill-judged ministrations constitute departures from the injunction "by the most conservative effective means" as well as from the caution, "to the extent indicated." Failure to respect these basic tenets identifies the untrained, inexperienced, or incompetent resuscitator.

There is yet another cardinal error of intrusive and pernicious management which demands discussion, to wit the administration of any of numerous available analeptics (nikethamide, alpha-lobelline, metrazole, megimide, etc.). The only preparation of this ilk which may be sanctioned at all is caffeine-sodium benzoate (30-50 mg. IV in the neonate), and even its rationale is tenuous[9]. Stimulants occasionally produce an apparent favorable response which is likely to be transient, but the ostensible benefit is bought at the cost of increasing the infant's oxygen debt[10]. Moreover, the absorption of parenteral drugs in a newborn whose peripheral circulation is essentially stagnant is undependable at best. The painful stimulus of the needle puncture in most cases, rather than the medication itself, is probably the determinant of immediate effect. There is no convincing data to support the conclusion that non-specific nervous system stimulants have a salutory influence on the neonate; their principal effect is to assuage the anxiety of the resuscitator. The same comments are applicable to sympathomimetic drugs such as ephedrine, methedrine, amphetamine, and others; neither their central nervous system nor cardiovascular actions have been found constantly favorable[11]. The intracardiac injection of small doses of epinephrine hydrochloride is similarly of doubtful value. If this is done one-half milliliter of the standard preparation of the agent (1 mg. per ml.) should be diluted to 10 ml. and administered as one or two increments of one cubic centimeter each. There is one class of drugs, however, which is entirely proper if narcotic-analgesics given to the mother during labor are the cause of neo-natal depression, namely, the narcotic antagonists nalorphine and levallorphan[12]. When these are employed, however, it must be realized that they counteract only the narcotics and that they will further diminish responsiveness if administered as antidotes to barbiturates, other hypnotics, or anesthetics. In no sense are these useful drugs stimulants *per se*, rather the contrary.

The last subject which should be discussed before proceeding to the positive aspects of management is mechanical or physical stimulation. This question may be dispensed with briefly; only gentle stimulation of the infant is acceptable. Resounding slaps, hot and cold immersion, and other traumatic procedures used in the past have no proper place in resuscitation. The most energetic mechanical manoeuvers which are proper are flicking or gentle slapping of the extremities, gentle massage, or the injection of parenteral medications (such as vitamin K) where this is a customary part of neonatal care.

The scope of the significant admonitions, "to the extent indicated, by the most conservative effective means, in the shortest possible time," could be elaborated at greater length; but enough has been said to suggest both their direct import and numerous connotations. Indirect and negative facets of the problem having been examined at some length, the positive features of neonatal resuscitation will now be discussed.

The active mandates of the epitome are (1) "assure pulmonary ventilation" and (2) "support cardiovascular function." The first requisite for ventilation is, of course, the establishment and maintenance of a clear airway, whether expansion of the lungs is to be achieved spontaneously or artificially. Cleansing the airway begins with simple common-sense methods which may be applied during or immediately following birth. The nose, mouth, and pharynx are freed of mucus, amniotic fluid, regurgitated gastric

(Continued on Page 1045)

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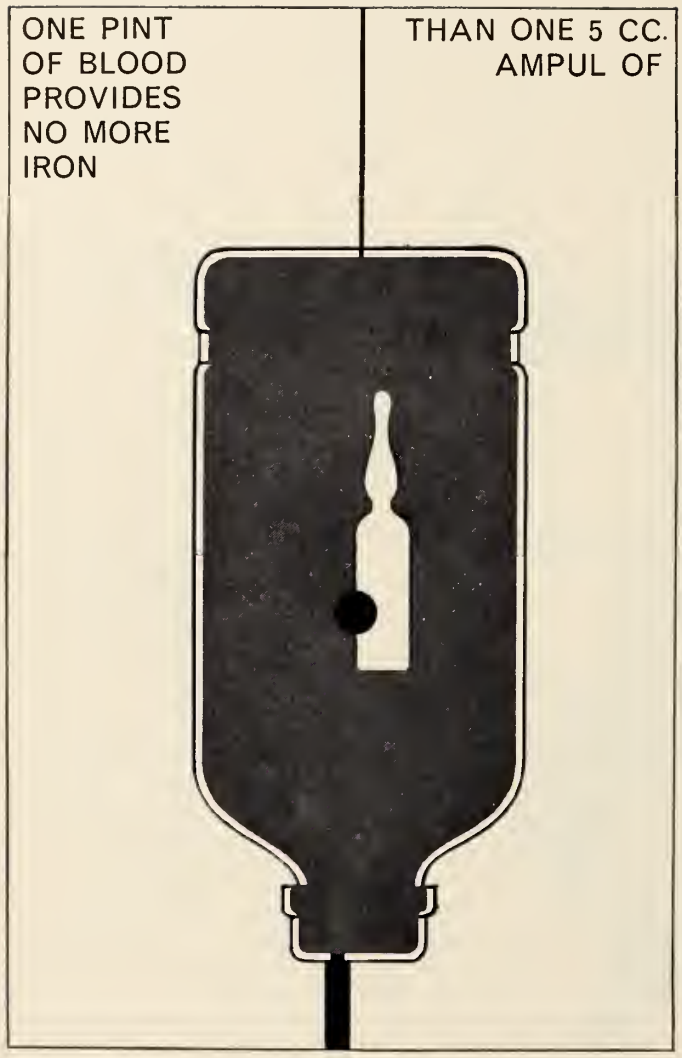
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COMPOSITION: Imferon (iron dextran injection) is a well-tolerated solution of iron dextran complex providing an equivalent of 50 mg. in each cc. The solution contains 0.9% sodium chloride and has a pH of 5.2-6.0. The 10 cc. vial contains 0.5% phenol as a preservative.

ADMINISTRATION AND DOSAGE: Dosage, based upon body weight and Gm. Hb./100 cc. of blood, ranges from 0.5 cc. in infants to 5.0 cc. in adults, daily, every other day, or weekly. The total iron requirement for the individual patient is readily obtainable from the dosage chart in the package insert. Deep intramuscular injection in the upper outer quadrant of the buttock, using a Z-track technique, (with displacement of the skin laterally prior to injection), insures absorption and will help avoid staining of the skin. A 2-inch needle is recommended for the adult of average size.

SIDE EFFECTS: Local and systemic side effects are few. Staining of the skin may occur. Excessive dosage, beyond the calculated need, may cause hemosiderosis. Although allergic or anaphylactoid reactions are not common, occasional severe reactions have been observed, including three fatal reactions which may have been due to Imferon (iron dextran injection). Urticaria, arthralgia, lymphadenopathy, nausea, headache and fever have occasionally been reported. Initial test doses of 0.5 cc. are advisable.

PRECAUTIONS: If sensitivity to test doses is manifested, the drug should not be given. Imferon (iron dextran injection) must be administered by deep intramuscular injection only. Inject only in the upper outer quadrant of the buttock, not in the arm or other exposed area.

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(Continued from Page 1042)

contents if present, and other debris by careful suction using a soft rubber bulb or catheter. This procedure should be carried out with care but thoroughness in the first few seconds of independent existence. In addition to clearing the air passages, it will also reveal anomolies of the mouth and upper respiratory tract. Choanal atresia is easy to overlook, for example, and it may occasion great difficulty since quiet breathing is invariably nasal in the newborn. During the interval of suctioning, the infant should also be positioned so that gravity will aid in draining the airway. It is apparent that some degree of head-down posture is desirable, but this must not be so extreme as to produce significant cerebral venous congestion, which is manifestly undesirable. The infant should certainly not be suspended by his feet, an all too common practice. As soon as the upper respiratory passages are clear, the baby should be positioned in perhaps ten degrees of head-down position and partially turned on one side so that further drainage from the lower respiratory tract will gravitate to the posterior pharynx and away from the larynx, which may be irritated by foreign material causing spasm. At the same time the head and neck of the child must be so disposed that the possibility of soft-tissue obstruction (soft palate, tongue) is minimized; this purpose is best served by the "sipping posture." Proper positioning is of paramount importance and is too frequently neglected. At this point, if the child is responding and breathing well, the administration of oxygen at ambient pressure for a minute or two, conservation of body heat by warm bath blankets, and a period of close observation are all that is required. This uncomplicated case will not be so easily handled, however, if the situation is improperly assessed, the airway remains obstructed, hypothermia is allowed, or a restrictive posture with flexion of the neck as on a hard flat table is permitted.

Not all neonates may be supported adequately by such conservative devices. Intrapartum distress, difficult delivery, prematurity, and any of a number of maternal complications should alert the knowledgeable physician that the infant may be notably distressed at birth and suggest also the possibility of a stormy post-natal course. The Apgar score of such infants is often less than seven; scores of four to seven are cause for concern and scores below four are associated with a grave prognosis[5]. The initial resuscitative endeavour remains unchanged in such babies, but it should be completed as quickly as possible. Within the first minute of life, intermittent positive pressure oxygen should be administered by mask at a rate of 25 to 30 breaths per minute. If this is not effective in producing improvement in heart rate and color, or if expansion of the lungs is not definite within 30 seconds, the airway must be re-evaluated and decision made to insert an oropharyngeal airway or a "Resuscitube" (depending on the technique to be used) in order to prevent soft tissue from compromising the air passages, a likely event in the flaccid areflexic newborn. Oxygen is once more applied intermittently; if there has been no evidence of expansion of the lungs at positive pressures of 15 to 25 cm. of water, which will have been used until now, then one or two attempts to inflate the lungs using pressures of 40 - 50 cm. water for a second or more each time should be made. Alternately, the resuscitube for mouth-to-mouth respiration offers helpful awareness of the effects of his ministrations to the operator and is preferred by some. When the latter device is used, the infant should be protected from pathogens by the interposition of a sterile sponge between the operator and the airway, and an elevated oxygen concentration for the infant may be obtained by means of a catheter or tube which delivers oxygen into the resuscitator's mouth. Mouth-to-mouth, mouth-to-nose, or mouth-to-airway ventilation of the neonate is a precise technique in which the muscles of the face and pharynx, rather than forceful expiratory efforts, are used to force the gases into the infant's lungs;

another description suggests "short puffs." The newborn respiratory volume is small so that excessive volume from strenuous adult exhalation is likely to force gases down the esophagus causing distention of the gastrointestinal tract. It should also be noted that the apparent "compliance" of the stomach of a depressed infant and the quality of respiratory movement of the trunk are such that even experienced individuals may be deceived and actually "ventilate" the stomach instead of the lungs. This is especially likely to occur before the initial expansion of the lungs, again a probable situation in the severely depressed newborn whose pulmonary compliance is extremely low. Details of neonatal pulmonary responses are well described in the work of Avery[15].

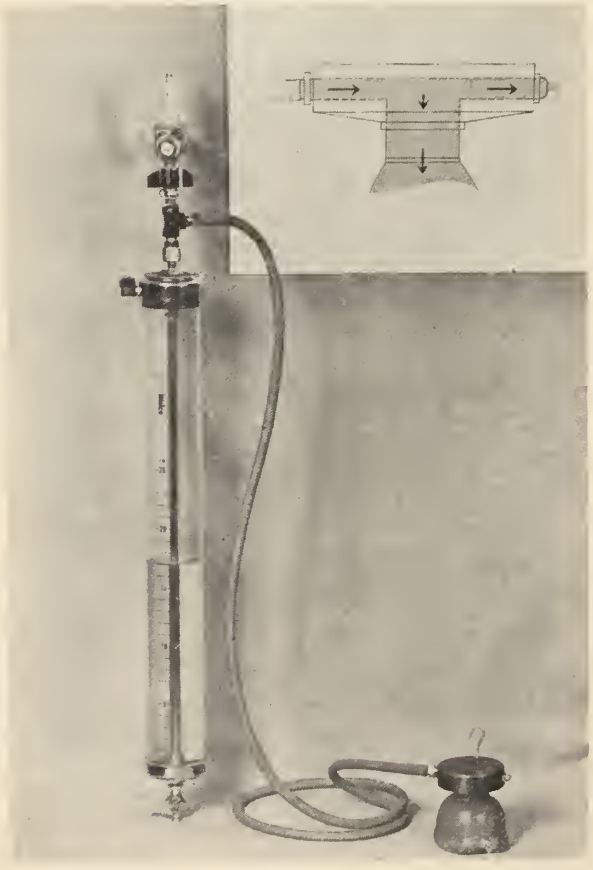


FIGURE 1

Manometric resuscitator and diagram of mask adaptor. This device is available from Melchior, Armstrong, Dessau, Inc., 730 Grand Avenue, Ridgefield, New Jersey, for approximately $60.



FIGURE 2

Simple bag and mask with non-rebreathing valve; a Fink valve is shown here but others are equally useful.

A number of methods are suitable for the respiratory support of the infant[16]; most of them are designed to allow for the administration of oxygen either at ambient pressure or at positive pressure as required. Figure 1 illustrates the manometric resuscitator which is used at University Hospital. The passage through the mask adapter prevents pressure build-up at low flows (2-5 liters), while at higher flows (6-8 liters) intermittent closure of the exit port with the finger affords assistance to ventilation. It will be apparent that the maximum pressure is not easily adjusted since it is determined by the manometer, and also that the mask pressure exceeds the height at which the water column vents when high flows are used. Another simple method is the bag and mask using either a non-rebreathing valve (Stevens-Slater, Ruben, Fink, *etc.*) (Figure 2), or a non-rebreathing, pressure-relieving elbow[17] with a four liter oxygen flow (Figure 3). These simple apparati, costing approximately $90, are also easy to use, adequate, and essentially foolproof. Any of these devices may also be adapted to an endotracheal tube when indicated (*vide infra*). Using such straightforward equipment, the inspiratory pressure is controlled readily by the hand; or an aneroid (or water) manometer may be easily attached to the equipment of Figures 2 or 3 for actual measurement if preferred. In addition to these modest systems, there are numerous

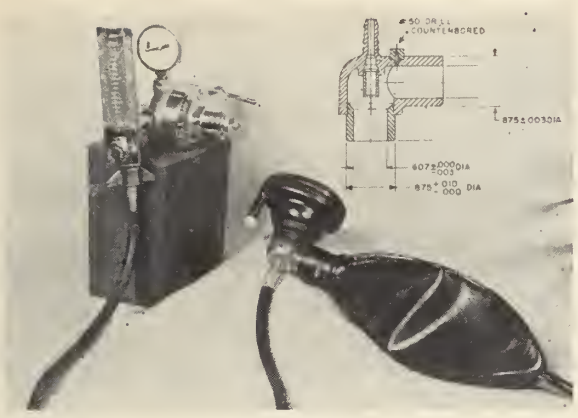


FIGURE 3

The inset shows the construction of the non-rebreathing pressure-relieving (NRPR) elbow, a development of Doctors Robert Hustead and Herbert J. Krier of Kansas City, Kansas. Prototpye elbows are available from Hans Rudolph, Inc., 7200 Wyandotte, Kansas City, Mo., for about $10.

machines in the category of "infant resuscitator," many of which offer easy alteration of pressure which is obviously desirable, a choice of automatic or manual cycling which is not an unmixed blessing, and built-in "safety features" which are beyond the control of the operator. This gadgetry is quite acceptable for the experienced resuscitator, but it cannot be recommended for the tyro or the occasional operator. Too frequently such machines become a substitute for reasoned methodology. Their virtue has unfortunately been over-rated; gadgetry has too often been credited for a favorable outcome of natural events, *post hoc ergo propter hoc.*

If attempts to ventilate a newborn by these conservative means have been unsuccessful at the end of two and one half minutes after birth—that is to say if there has been no definite improvement in heart rate, color, tone, reflex responsiveness, or ventilation by that time—intubation of the trachea is indicated. This is a simple atraumatic procedure in the unresponsive infant. Briefly, the technique is as follows:

A: Using a straight blade (Wis-Forreger, Flagg, Murphy, Guedel, etc.)

1. Position the child so that the neck is fully (but under no circumstances forcefully) extended. This may usually be accomplished satisfactorily by placing a pad one to two inches thick under the baby's shoulders.

2. Insert the laryngoscope gently through the right side of the mouth, displacing the tongue to the left. Advance the blade slowly under direct vision until the posterior pharyngeal wall is visualized.

3. Tilt the laryngoscope so that its tip points toward the presumed location of the larynx *WITHOUT TOUCHING THE MAXILLA WHICH MUST NEVER (NEVER!) BE USED AS A FULCRUM.* The laryngoscope is *not, repeat not,* a lever. With this manoeuvre, the epiglottis will come in view. The blade is advanced just on to the epiglottis.

4. The lower jaw is then lifted, applying the forces in an upward direction—the same direction that the handle of the instrument is pointing. The handle must not arc cephalad toward the operator since this not only makes it a lever but diminishes space to insert the tube. The operator will now be looking through the larynx and into the trachea, and passing the tube can be accomplished easily.

B: Using a curved blade (MacIntosh, Guiffrida, Gabuya, Fink, *et al.*)

1. Place the infant's head in a "sipping" posture by means of a pad about one inch thick under the occiput (the neck is *not* flexed in this position).

2. Insert the blade into the right side of the mouth as before, displacing the tongue to the left as the blade is moved toward the center of the mouth. Advance the blade under direct vision along the curve of the base of the tongue until the epiglottis is in view. Place the blunt rounded end of the blade in the epiglottic fold.

3. Just as with the straight blade, the curved blade must not bear on the

maxilla nor be used as a lever. The vector for application of forces, as before, is indicated by the laryngoscope handle. As the mandible is displaced in this direction, the larynx and trachea are exposed and intubation is simple.

Skill at intubation is possible only by practice; the occasional still-born infant affords an opportunity for those interested to familiarize themselves with the procedure. Unless the tube is certainly in the trachea, resuscitative measures may fail; BY THE TIME INTUBATION IS UNDERTAKEN THERE IS NO JUSTIFICATION FOR UNCERTAIN MEASURES and the most competent operator present should do the procedure. Other important cautions in regard to tracheal intubation are two. First, the distance from the jaw to the larynx in the newborn is short, and it is very easy to err by advancing the laryngoscope into the esophagus so that force is applied to the back of the larynx. This is extremely traumatic and likely to cause laryngeal edema with subsequent airway difficulty. Approaching the larynx, as described above, under direct vision prevents this harmful accident. Second, the length of the infant trachea is short, and a tube may readily be advanced into the right main bronchus obstructing ventilation of the left lung. This may be guarded against by the use of the Cole tube (Figure 4), which has the added advantage of better flow characteristics than the plain tube. Even using this type of endotracheal catheter, however, it is essential to be certain that both lungs are being aerated by observation and auscultation; the possibility of trauma leading to mediastinal emphysema must also be considered, or it may be missed. The endotracheal adapter illustrated will connect directly to all standard anesthesia equipment, including both non-rebreathing valves (Figure 2) and the NRPR elbow (Figure 3); thus no change in "set-up" is required after intubation. In the infant with unexpanded lungs the major conducting portion of the pulmonary tree below the larynx is filled with fluid, and the alveoli are kept collapsed by strong surface forces. Pressures as high as 50 - 60 cm. H_2O for periods of one to three seconds may be required to initiate pulmonary expansion, which will sometimes be appreciated by a sensation of crepitation to the operator. This extreme tactic should be limited to perhaps two applications since rupture of alveoli or congenital blebs leading to pneumothorax is a distinct possibility. After initial pulmonary expansion ventilation becomes easier. A flat film of the chest is probably desirable after intubation or other extreme resuscitative measures. Once spontaneous respiration is established, remaining portions of atelectatic tissue will gradually be opened by physiological forces during the ensuing 24 to 48 hours. The extreme inspiratory pressure of 50 - 60 cm. water should be used only in the occasional newborn who requires it; if ventilation is posssible at lower pressures, vigorous assistance of this order must be shunned.



FIGURE 4

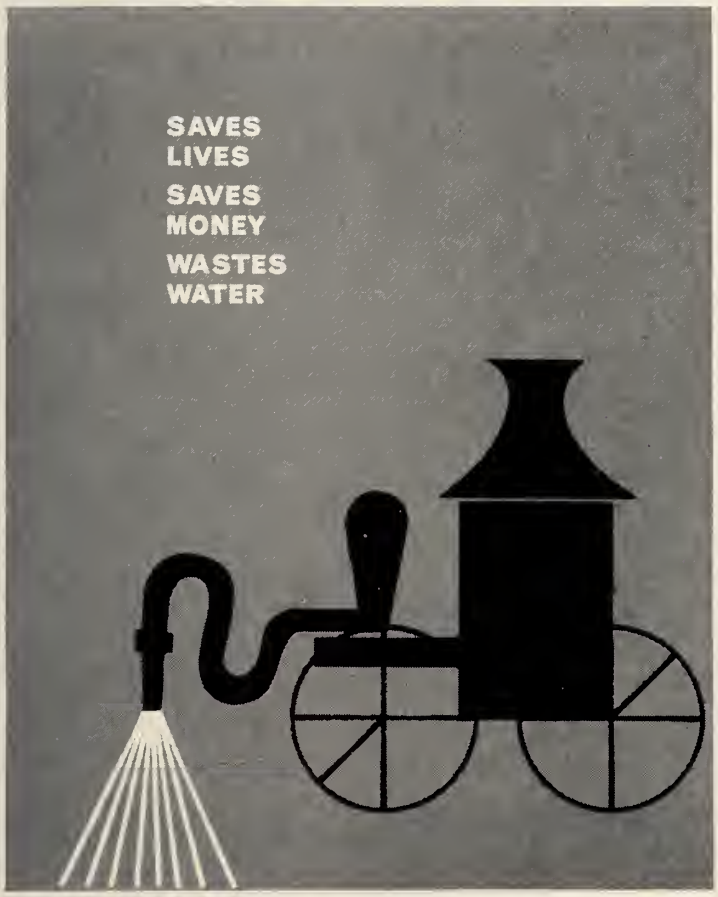
Cole tube and adaptor.

As soon as the infant starts to resist or reject the artificial airway, it should be removed immediately; and intermittent positive pressure should be continued by mask if required.

In the depressed neonate who is normal and viable, and who has any detectable heartbeat, the ventilation of the lungs with oxygen enriched gases usually causes a

(Continued on Page 1050)

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Side Effects: Nausea, flushing, constipation, skin rash, muscle cramps and gastric discomfort have occasionally been noted; rarely thrombocytopenia and bone marrow depression, photosensitivity, cholestatic jaundice, pancreatitis, perimacular edema, gout and diabetes have been caused by the administration of thiazides.

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(Continued from Page 1048)

prompt improvement in cardiac and vascular function. If a heartbeat is not detectable and ventilation of the lungs does not produce a prompt cardiac response, the pliable infant thorax lends itself readily to external "cardiac massage." The average adult male can reach easily around the flexible infant chest with one hand and depress the lower end of the sternum toward the vertebrae column two to three centimeters with the thumb, using very light pressure, to propel blood from the heart effectively; but it is clear that this has little purpose without ventilation. If external cardiac massage proves beneficial, this is usually apparent within one or two minutes. It must be remembered also that the depressed neonate may be severely acidotic; for this reason the administration of sodium bicarbonate and glucose[18] (initial dose 5 cc. 15% $NaHCO_3$ + 5 cc. 10% dextrose) will often prove beneficial. In all cases it is most urgent that during the time while special drugs or equipment are being procured, the infant *must not be neglected.*

A final point of concern should be presented in this account, specifically the suctioning of the trachea and the stomach. If the trachea is obstructed by mucus, its removal is necessary to establish respiration; the tenacious material cannot be expelled by the natural process of coughing, a function which is impossible for the unexpanded lung. The infant trachea is quite small, however, and a suction catheter of minimal effective diameter must be used. It should also be remembered that strong suction will diminish pressure in the air passages below atmospheric, tending to collapse any portion of the lung which has expanded and otherwise to maintain the unexpanded condition. This procedure should, therefore, be done gently, minimally, and at moderate negative pressures; the catheter should, of course, be passed through an endotracheal tube in order to be certain of its placement. The practice of emptying the stomachs of cesarean section babies has prevailed for about two decades. This procedure may be indicated in infants who are distended or who regurgitate gastric contents repeatedly. If the infant is doing well without passing a catheter into the stomach to empty it, this is a meddlesome technique since it may cause either active vomiting in the vigorous infant, relaxation of the cardiac sphincter leading to upward flow of material by gravity in the depressed, as well as apnea or bradycardia from vagal reflexes during the period of instrumentation. Irritating material in the pharynx is also a likely cause of laryngospasm, which cannot always be treated easily. The passage of a catheter into the stomach should never be done prophylactically, then, but only on the indication of repeated regurgitation.

If the response to resuscitative procedures is poor, if there are recurrent episodes of respiratory difficulty after initial apparent success, or if the infant remains cyanotic after effective ventilation with an apparently good heart beat, any of several anomalies, intracranial hemorrhage from birth trauma or pneumothorax or mediastinal emphysema caused by positive pressure or instrumentation may be present. Persistent retraction of the rib cage on inspiration with continuing cyanosis suggests either incomplete expansion of the lungs or "hyaline membrane" disease. Discussion of these disturbances is more properly undertaken by a pediatrician than an anesthesiologist, and they are not pertinent to the immediate problem of resuscitation. Resuscitative efforts should be continued as long as appears life and evidence of favorable response. The fact that the infant does not breathe spontaneously or seems to relapse when supportive efforts cease does not justify termination of indicated therapy. Occasionally it may be necessary to maintain the infant artificially for as long as an hour; and even the more prolonged use of artificial ventilators is sometimes graced with a favorable outcome, although there is little reason for optimism in such cases. As the

(Continued on Page 1053)

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(Continued from Page 1050)

immediate neonatal period lengthens, blood gas studies, pH, electrolyte determinations, and the electrocardiogram become essential guides to proper management.

In summary then, the following may be stated:

1. Resuscitate the newborn with simple, atraumatic, commonsense procedures;
2. Assure pulmonary ventilation and effective cardiovascular function in the shortest possible time;
3. Use the most conservative means; avoid drugs, vigorous stimulation, and traumatic techniques. Observe indications both inclusively and exclusively.

REFERENCES

1. Apgar, V.: A Proposal for a New Method of Evaluation of the Newborn Infant. Anesthesia and Analgesia. 32:260, 1953.

2. Auld, P. A. M., Rudolph, A. J., Avery, M. E., Cherry, A. M., Drorbaugh, J. E., Kay, J. L. and Smith, C. A.: Responsiveness and Resuscitation of the Newborn. Am. J. Dis. Child. 101: 713, 1961.

3. Smith, B. E., and Moya, F.: Resuscitation of the Depressed Newborn. Anesthesiol. 26: 549, 1965.

4. Meschia, G., Cotter, J. R. and Breathnach, C. S., and Berron, D. H.: The Hemoglobin, Oxygen, Carbon Dioxide, and Hydrogen ion Concentration in Umbilical Bloods of Sheep and Goats as Sampled via Indwelling Plastic Catheters. Quart. J. Exp. Physiol. 50: 185, 1965.

5. Glass, H. B., Snyder, T., and Webster, C.: Rate of Decline in Resistance to Anoxemia of Rabbits, Dogs, and Guinea Pigs from Onset of Viability to Adult Life. Am. J. Physiol. 140: 609, 1944.

6. Shields, L. V., and Taylor, E. S.: Serial Oxygen Saturation Studies of Newborn Infants Following Obstetrical Complications, Difficult Deliveries, and Cesarean Section. Am. J. Obst. Gyn. 73: 1011, 1957.

7. Hodges, R. J. H., Wilson, E. J., Knight, R. F. and Tunstall, M. E.: Some Factors Associated with Neonatal Depression in Operative Obstetrics. Brit. J. Anaes. 32: 16, 1960.

8. Drage, J. E., Kennedy, C., Schwarz, B. K.: The Apgar Score as an Index of Neonatal Mortality: a report of the collaborative study of cerebral palsy. Obst. Gyn. 24: 222, 1964.

9. Special Committee on Infant Mortality of the Medical Society of the County of New York: Resuscitation of Newborn Infant. Obst. Gyn. 8: 3, 1965.

10. Eastman, N. J., and Kreiselman, J.: Treatment of Experimental Anoxia with Certain Respiratory and Cardiac Stimulants. Am. J. Obst. Gyn. 41: 260, 1941.

11. Brown, R. J. K.: Respiratory Difficulties at Birth. Brit. Med. J. 1: 404, 1959.

12. Eckenhoff, J. E., Hoffman, G. L., and Funderburg, L. W.: N-Allylnormorphine: An Antagonist to Neonatal Narcosis Produced by Sedation of the Parturient. Am. J. Obst. Gyn. 65: 1269, 1953.

13. Avery, M. E., Chernick, V., Dutton, R. E., and Permutt, S.: Ventilatory Response to Inspired Carbon Dioxide in Infants and Adults. J. Appl. Physiol. 18: 895, 1963.

14. Avery, M. E., and Mead, J.: Surface Properties in Relation to Atelectasis and Hyaline Membrane Disease. Am. J. Dis. Child. 97: 517, 1959.

15. Avery, M. E.: The Lung and Its Disorders in the Newborn Infant. W. B. Saunders Co., Philadelphia, 1964.

16. Abramson, H, Ed.: Resuscitation of the Newborn Infant. C. V. Mosby Company, St. Louis, 1960.

17. Hustead, R.: Personal Communication.

18. Cross, K. W.: Resuscitation of the Asphyxiated Infant. Brit. Med. Bull. 22: 73, 1966.

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A Revised Curriculum For The Medical College Of Alabama

T. Albert Farmer, Jr., M. D.*

Introduction

During recent years, research and investigation have resulted in an explosion of scientific knowledge unparalleled in any previous era. Since in no field is this more evident than in the field of medicine, the exploration of better ways of imparting this knowledge to potential physicians has become paramount in the eyes of medical educators throughout the world. Medical education in the United States has been studied more intensely during the past decade than at any other time since *The Flexner Report* which resulted in the curriculum presently used by most medical schools (Flexner, 1910). The awareness of the significance of these needs has resulted in drastic curricular changes at several medical schools throughout the United States. At Western Reserve University, the Medical College of Virginia and Northwestern University, one result of these changes has been to integrate the programs of teaching through inter-disciplinary subject committees. The University of Rochester has increased elective time and instituted the undifferentiated clinical clerkship. The presentation of pre-clinical material has been limited to the first year at Duke University with the application of increased flexibility for the individual student after the first year. Other notable efforts have been Stanford's plan for extension to five years of medical school after three years of under-graduate school, Johns Hopkins' five year program with provision for two years of undergraduate training prior to an intensive first year of medical school and the combination of some under-graduate studies with basic science medical studies in the programs at Boston College and Wayne State (Lee, 1965). These are only a few examples, representative of changes which are underway in many medical schools throughout this country. The variability in the approaches taken to curricular improvement has emphasized the need for clear definition of aims and objectives prior to careful planning and effective execution of curricular change.

Planning

On February 22, 1963, departmental and divisional chairmen of the Medical College of Alabama met with two committees (Curriculum Revision and Implementation) concerned with the curriculum of the Medical College for a two-day work conference at Ann Jordan Lodge. Their purpose was to discuss the present curriculum and to define principles, objectives and aims for a revision of the curriculum, the first major revision since the four year school was established in Birmingham in 1945. These productive discussions initiated a detailed year-long study by the Medical College Curriculum Revision Committee which culminated in their preliminary report of recommendations dated December 11, 1963. This report was discussed in considerable detail by all members of the faculty and written critiques, comments and suggestions were submitted by each departmental chairman and other senior faculty members at a series of discussions within the Faculty Policy Committee. Subsequent to this, the Curriculum Revision Committee met with each departmental chairman and other faculty members in an

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*Assistant Professor of Medicine and Assistant Dean for Curriculum Affairs, Medical College of Alabama.

attempt to incorporate their suggestions in an amended report which was submitted on February 1, 1965.

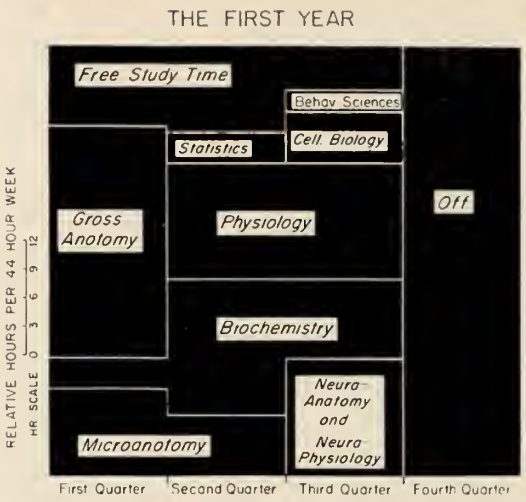
Recommendations of the Curriculum Revision Committee

The committee defined three major objectives as paramount in medical education:

1. Development of a sense of responsibility to patients and to society.
2. Development of a critical and inquiring attitude of mind, so that a continuing process of self-education is nurtured.
3. Education towards an understanding of fundamental principles and basic procedures and skills of modern medicine.

It was further determined by the committee that basic deficiencies did exist in the present program. Perhaps the most profound of these was the lack of success in stimulating independent thought and study, and seemed to result primarily from the rigidity of the curriculum and its lack of balance. The students needed more time for electives and special instruction in some areas in order to adapt more easily the program to fit the needs of the individual student. A need was seen for coordination in teaching with greater emphasis on basic principles throughout the entire four years, closer correlation of clinical material with basic science teaching and a better coordination of subject material in various disciplines.

The recommendations proposed by the Curriculum Revision Committee to overcome these deficiencies, in relation to the objectives set forth, were approved on March 17, 1965 by the Faculty Policy Committee and on March 24, 1965 by the Faculty Council of the Medical College of Alabama. The implementation of these changes was begun in June of 1965 in an orderly and progressive fashion with the projected curricular revision to be completed by September of 1966.

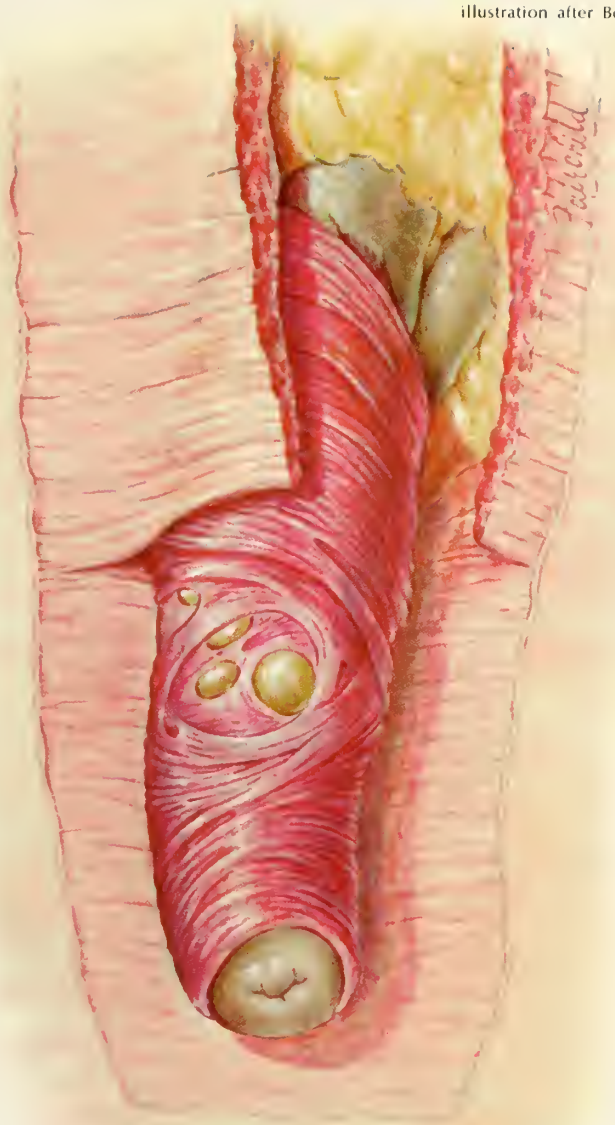


The First Year

The Medical College will adopt the quarter system in the first year with twelve weeks per quarter. Saturday morning during the first and second quarters and Wednesday afternoon during the second and third quarters will be free of scheduled assignments for individual study time. As shown in Figure 1, the first year will provide for the acquisition of knowledge of the various aspects of human biology, beginning with the structural and biochemical foundation and progressing to an understanding of its dynamics. During the third quarter of the first year, a new course in Cell Biology will unify the basic science disciplines through study of cell structure, cellular genetics, energy transformation, membrane transport and intercellular relationships. In order to avoid inter-departmental conflict between examinations and individual course attentiveness, regular periods have been set aside as examination times. During the first quarter every Wednesday morning will be used for this purpose. During the second quarter there will be three examination periods, four weeks apart, with the first two of these consisting of all day Tuesday with half day on Wednesday morning and the last of these

(Continued on Page 1059)

illustration after Boyden



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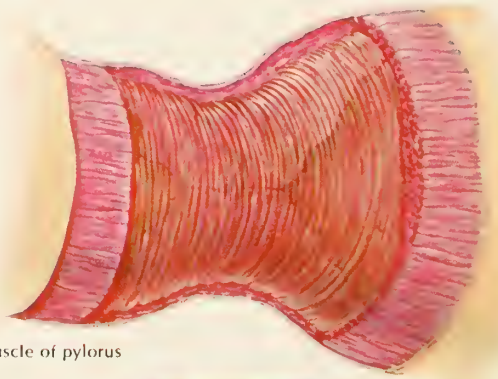
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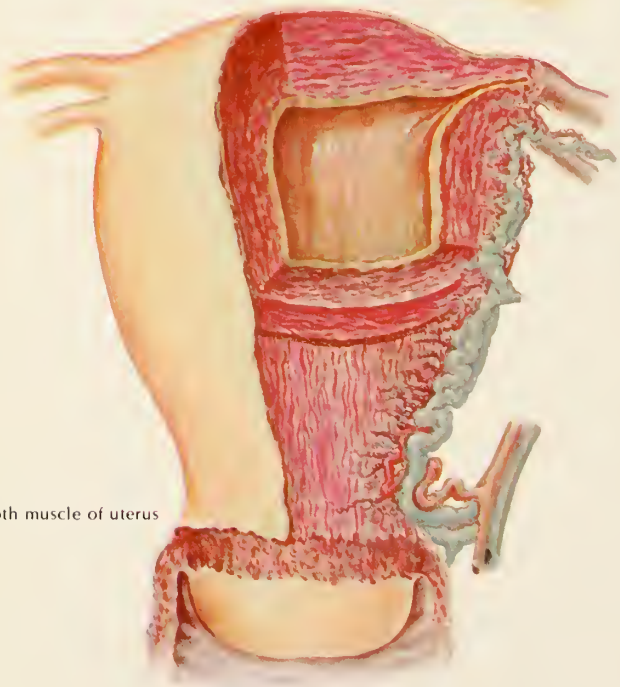
smooth muscle sphincter of Oddi



smooth muscle of pylorus



smooth muscle of colon

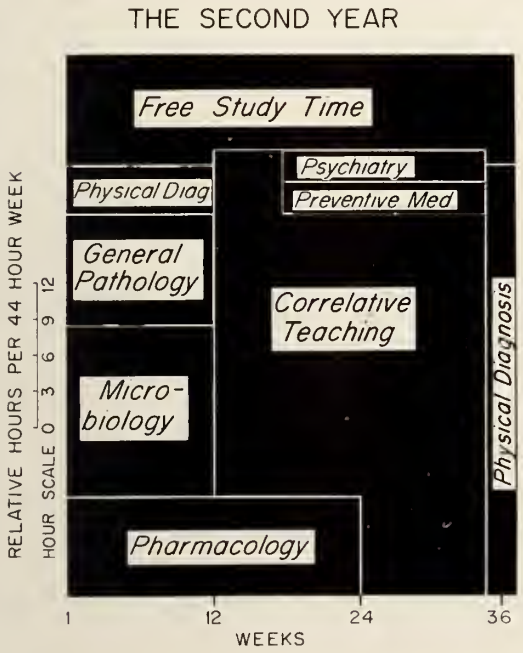


smooth muscle of uterus



smooth muscle of urinary bladder

consisting of half day Wednesday afternoon and all day Thursday. In the third quarter there will be only a mid-quarter exam period, consisting of all day Tuesday and all day Wednesday and at the end of the quarter a comprehensive examination period to include Wednesday afternoon through Saturday morning. This segment of the revised curriculum will be in effect with the class beginning in September of 1965.



The Second Year

In arranging the curriculum, the second year is regarded as a continuum of thirty-seven weeks interrupted by vacation periods at Christmas and Spring Holidays. A large part of the teaching for the second year will be based on organ systems. As shown in Figure 2, early in the second year basic principles of Pharmacology, Microbiology, Pathology and Physical Diagnosis will be taught in preparation for the correlative teaching program. A drastic pruning of the formal hours for Medicine, Surgery, Systemic Pathology, Psychiatry, Obstetrics and Public Health has been done in order to include these disciplines in a correlative organ system teaching program. The alterations of structure and function produced by various diseases will be related to the normal and correlated with the clinical manifestations during this period. The natural history of a disease and the basic mechanisms involved are to be emphasized in live seminars. At the end of the second year, intensive instruction in history-taking and physical examination will be given for a two week period in order to relate further the organ system knowledge acquired to the coming clinical years. In addition, a series of lectures in Preventive Medicine, as well as in the Behavioral Sciences as they relate to Psychiatry, will be given. Unscheduled time during the work week will be assigned into blocks (two afternoons per week) in order to permit the student to utilize his time more effectively. The details of this second year portion of the revised curriculum which will be instituted in September of 1966 are still under consideration. The correlative teaching program is being managed by a small committee, chaired by a member of the Department of Pathology with two assistant coordinators, one from the Department of Physiology and one from the Department of Medicine. This committee is responsible for the overall design of the course in correlative teaching, scheduling the systems to be included in the program and establishing sub-committees responsible for each system, which include growth and development, the cardiovascular system, respiratory system, urinary system, digestive system, hematopoietic system, musculoskeletal system, endocrine and reproductive systems, nervous system, sensory system and the integument.

The Clinical Years

During the third and fourth years of the medical school curriculum, the student spends fifteen months in clinical clerkships with five months on Medicine, five months on Surgery, two months on Obstetrics and Gynecology, two months on Pediatrics and one month on Psychiatry. The other nine months of the clinical years' time include

CLINICAL YEARS

JUNIOR CLASS BEGINNING JUNE OF 1965

GROUPS	QUARTER	SUMMER	FALL	WINTER	SPRING	SUMMER	FALL	WINTER	SPRING
	QUARTER #	1	2	3	4	5	6	7	8
1		MMM	P^1OG	SSS	---	OFF	---	MMP_2	SSP^2
2		OFF	SSS	P^1OG	MMM	SSP^2	---	---	MMP_2
3		SSS	OFF	MMM	P^1OG	MMP_2	SSP^2	---	---
4		OFF	MMM	---	SSS	P^1OG	MMP_2	SSP^2	---

M - MEDICINE
S - SURGERY
P^1 - PEDIATRIC WARDS
P^2 - PEDIATRIC CLINICS
O - OBSTETRICS
G - GYNECOLOGY
P_2 - PSYCHIATRY
--- - ELECTIVES

six months on required electives and three months as an optional period used for vacation, remunerative jobs or for a continuation of his academic program. The three months optional period is taken during one of the quarters of the junior year.

Any lectures in the clinical disciplines are given in the block time assigned to each department with sub-specialty teaching being incorporated into the departmental blocks of time. The Department of Surgery includes teaching in orthopedics, urology, neurosurgery, anesthesiology, otolaryngology and plastic surgery. The Department of Medicine includes sub-specialty teaching in public health, preventive medicine, dermatology, neurology, radiology and ophthalmology. The Department of Pediatrics in a similar fashion incorporates teaching in public health and preventive medicine.

An Elective Approval Committee has been established to review each required elective offered to insure the highest possible educational value to the student. Under the required elective program, several types of educational opportunity exist:

1. Clinical clerkships of one or more months duration in each clinical department for the student who desires greater depth in a general clinical area and in each sub-departmental or divisional area such as urology, ophthalmology, cardiology, etc.

2. Research in either basic science or clinical areas for periods of at least three months.

3. Advance courses in the basic science areas and certain applicable clinical areas as well, which are of post-graduate caliber rather than repetition of under-graduate material.

Implementation of the revised curriculum for the clinical years was begun in June of 1965 with the class beginning their junior year at that time. These students will follow the schedule shown in Figure 3. All subsequent classes, at the beginning of their junior years, will follow the schedule as outlined in Figure 4.

CLINICAL YEARS

JUNIOR CLASSES BEGINNING JUNE OF 1966 AND THEREAFTER

GROUPS	QUARTER	SUMMER	FALL	WINTER	SPRING	SUMMER	FALL	WINTER	SPRING
	QUARTER #	1	2	3	4	5	6	7	8
1		MMM	P^1OG	SSS	OFF	---	---	MMP_2	SSP^2
2		OFF	SSS	P^1OG	MMM	SSP^2	---	---	MMP_2
3		SSS	OFF	MMM	P^1OG	MMP_2	SSP^2	---	---
4		---	MMM	OFF	SSS	P^1OG	MMP_2	SSP^2	---

M - MEDICINE
S - SURGERY
P^1 - PEDIATRIC WARDS
P^2 - PEDIATRIC CLINICS
O - OBSTETRICS
G - GYNECOLOGY
P_2 - PSYCHIATRY
--- - ELECTIVES

Curricular Administration

After approval of the recommendations of the Curriculum Revision Committee, a permanent Curriculum Implementation Committee was appointed with the Assistant Dean for Curriculum Affairs to act as coordinator for this group. Since the efficiency in the implementation of the new curriculum as well as continual reevaluation of curricular effectiveness is dependent upon a functional organizational structure, the appointment of teaching committees responsible for specific segments of the curriculum was a necessity. Three separate teaching committees have therefore been appointed, one for the first year of the Medical College, one for the second and one for the clinical years. These teaching committees are responsible for arranging schedules, correlation of teaching within their specific segment of the curriculum and with other segments of the curriculum and evaluating student performance during and at the end

(Continued on Page 1064)

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Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.



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(Continued from Page 1060)

of their particular segment of responsibility. Each of these teaching committees, after making plans for their specific part of the curriculum, is responsible to the Curriculum Implementation Committee for approval.

Student Preceptor Program

In an effort to cultivate the student's initiative and motivation in the proper direction, a student preceptor program has been established. There are forty faculty preceptors, each of whom is assigned two students at the beginning of their sophomore year with continuation of the role as preceptor throughout the remainder of the student's time in medical school. The preceptor serves as the student's advisor and the primary liaison for student-faculty relations. He is given the scholastic records of each student he is assigned and is expected to assist and advise the student in regard to his needs, desires and problems. The student calls upon his preceptor for advice concerning elective programs, socio-economic and scholastic difficulties and planning his future in many aspects, from the choice of an internship to his own particular medical career ahead. The warm understanding and personal relationship established should help to further the student's accomplishments in medical school toward the objectives outlined by the Curriculum Revision Committee.

Combined Degree Program

A combined program leading to the Master's Degree in basic medical sciences and to Doctorate in Medicine is offered to the student admitted to the Medical College with a baccalaureate degree. An undergraduate record indicating academic excellence and a background in differential and integral calculus, physical chemistry and advanced physics is a prerequisite to enrollment in the combined degree program. The Department of Anatomy, Biochemistry, Microbiology, Pharmacology and Physiology all offer graduate programs leading to the Master's and Doctoral Degrees. In addition, they participate in the combined program offered by the Institute of Growth and Development in providing opportunities for study and research in genetics, embryology, fetal physiology and gestation. On enrollment the student selects an approved sponsor from the graduate faculty of the University to supervise his research and the preparation of his thesis. Entrance into the Graduate School is scheduled early in June preceding the freshman year in the Medical College and a four year program including the summer quarters is pursued with the student receiving twenty-four hours of graduate credit in courses designed to provide a firm background in the basic medical sciences. Through the electives program of the revised curriculum, the student may expand his graduate credit toward his Master's Degree.

REFERENCES

Flexner, Abraham. 1910. Medical Education in the United States and Canada. The Carnegie Foundation for the Advancement of Teaching Bulletin Number Four.

Lee, Peter V. 1965. Experiments in Medical Education. Annals New York Academy of Sciences. In Press.

The Drug Without Side Effects

There exists an unrealistic public image of drugs that there could be remedial agents with various and optimum therapeutic effects without any toxicity. This is clearly utopian. The drug without side effects still remains to be discovered and it is most unlikely that it will ever be found.—Cornielle J. F. Heymans, M. D., in *Georgetown Medical Bulletin*, (18:174-175), February 1965.

Alabama Department of Public Health

Highlights Of 1965

Ira L. Myers, M. D.

Unprecedented victories in the public health field were achieved during the 1965 Legislative Year. Increased financing of basic health services was accomplished with the one cent cigarette tax, the first state wide tax package in Alabama passed exclusively for health purposes. The salary ceiling for professional personnel was abolished by another legislative act.

Implementation of existing programs was immediate: county health department budgets were increased by $442,000 which more than doubled any previous amount designated for county health work; the hospital service and cancer diagnosis and treatment programs for the indigent received $100,000 in additional funds; increases in salaries of about a quarter million dollars for all employees were scheduled; laboratory services in Selma, Dothan, and Huntsville were restored.

Increased responsibilities followed increased revenues. Governor George C. Wallace designated responsibility for Title 18 of the Medicare Act to the State Board of Health. This Agency was also selected as the Mental Retardation Construction Authority by the Governor during the year.

The increasing use of radiation in industry, medicine, etc., continued to pose an environmental health problem. Regulations governing the control of X-ray units in the medical arts profession were developed and adopted. A state wide leak testing survey of all known radium sources was completed. The Radiological Health Laboratory began operations in 1965 by analyzing milk and other samples for radioactive measurements and evaluation of their implications and significance.

Extension of the Hill-Burton Act during 1964 required a massive survey and inventory of all medical facilities in the State by the Division of Hospital Planning during 1965.

The Alabama Department of Public Health set aside $100,000 to insure a shellfish testing program to protect and enable the industry to survive and prosper safely.

A Narcotics Control Program was officially organized and began activities on a limited scale during November. The Division of Health Education and Information added a facet of service with the installation of photographic services in 1965.

Progress in the area of adequate hospital and nursing home facilities during the past

Presented to the Medical Association of the State of Alabama at its Annual Session April 21-23 in Mobile, Ala. by Ira L. Myers, M. D., State Health Officer.

ten years has been astounding. The completion of 360 general hospital beds during 1965 represents 87.21 per cent of the need being met as opposed to less than 40 per cent in 1947. Two health centers were completed, four were being built, and three were approved for construction during the year.

Activities in the nursing home field reached an all time high during the past year with 36 projects being completed. In ten years the percentage of need met in this area has increased from less than eight per cent to over 53 per cent.

The demands for services coming to home health agencies on July 1, however, may not be met in this or in other areas for years.

The Alabama Department of Public Health moved into an area of activity beyond anything which public health in this state had traditionally known. Involvement in the Medicare Program threatened public health with a shortage of facilities, as well as personnel to man these facilities.

Expansion of services confronted the Agency with new problems: shortage of manpower and facilities; reorganization at the federal, state and local levels; and delineation of responsibility.

Employees in public health increased at both the state and county level during 1965. However, strategic vacancies still existed. An acute shortage of all classifications of personnel remained—a nurse war was being fought in the presence of a physician famine. The Division of Public Health Nursing functioned throughout 1965 without a full-time director. Twenty-two health officers and one administrator directed the activities of 58 county health departments—eighteen serving multi-county units. Nine counties were without local administration. Many inspection activities within the jurisdiction of the Bureau of Sanitation were curtailed due to a shortage of trained personnel.

On October 1 the Division of Mental Hygiene, the State Mental Hospital System, and the State Commission on Alcoholism were merged to form the new Department of Mental Health. Some remnants of this program remained with the State Health Department, such as mental health construction. These agencies are still housed in office space provided by the Health Department.

Familiar enemies continued their attack. Tuberculosis remained Alabama's number one contagious disease with a 12½ per cent increase in cases reported for 1965. Diphtheria continued a gradual increase; three deaths resulted from this disease. There were more cases of primary, secondary, and early latent syphilis found during 1965 than in any year since 1949. The total number of cases reported was more than in any year since 1952. The "Blitz" method of treatment developed by the Bureau of Preventable Diseases, was successfully employed to quell an epidemic at Atmore Prison during 1965. This system was later utilized in several counties with outstanding results—the time from naming a contact, suspect, or associate, until he or she was examined and/or treated in the clinic averaged 11½ hours.

Accident fatalities continued rising. A pilot study, the only one of its kind in the nation, was conducted in Birmingham during 1965 to develop guide lines for the initiation of accident prevention programs in metropolitan area health departments throughout the United States.

The leading causes of death during 1965 continued to be heart disease, vascular lesions, and cancer. Pneumonia rates, diseases of the arteries, and diabetes were up. Homicides and suicides increased also.

For the first time in history not a single case of poliomyelitis was reported in the state. The maternal mortality rate was reduced by 29.6 per cent during 1965 over last year. Thirty-four maternal deaths, the lowest number ever recorded were reported in 1965. It is significant that over one-fourth of the pregnant women delivered during the year depended upon services of their county health departments.

A reduced birth rate in 1965 may be at-

(Continued on Page 1070)



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EACH TABLET CONTAINS:
Pentobarbital Sodium..... 25 mg.
Secobarbital Sodium..... 25 mg.
Butabarbital Sodium..... 7.5 mg.
Phenobarbital..... 7.5 mg.
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Dosage: One or two tablets, one-half hour before bedtime.

Indications: For night-time sedation and refreshing sleep up to eight hours.

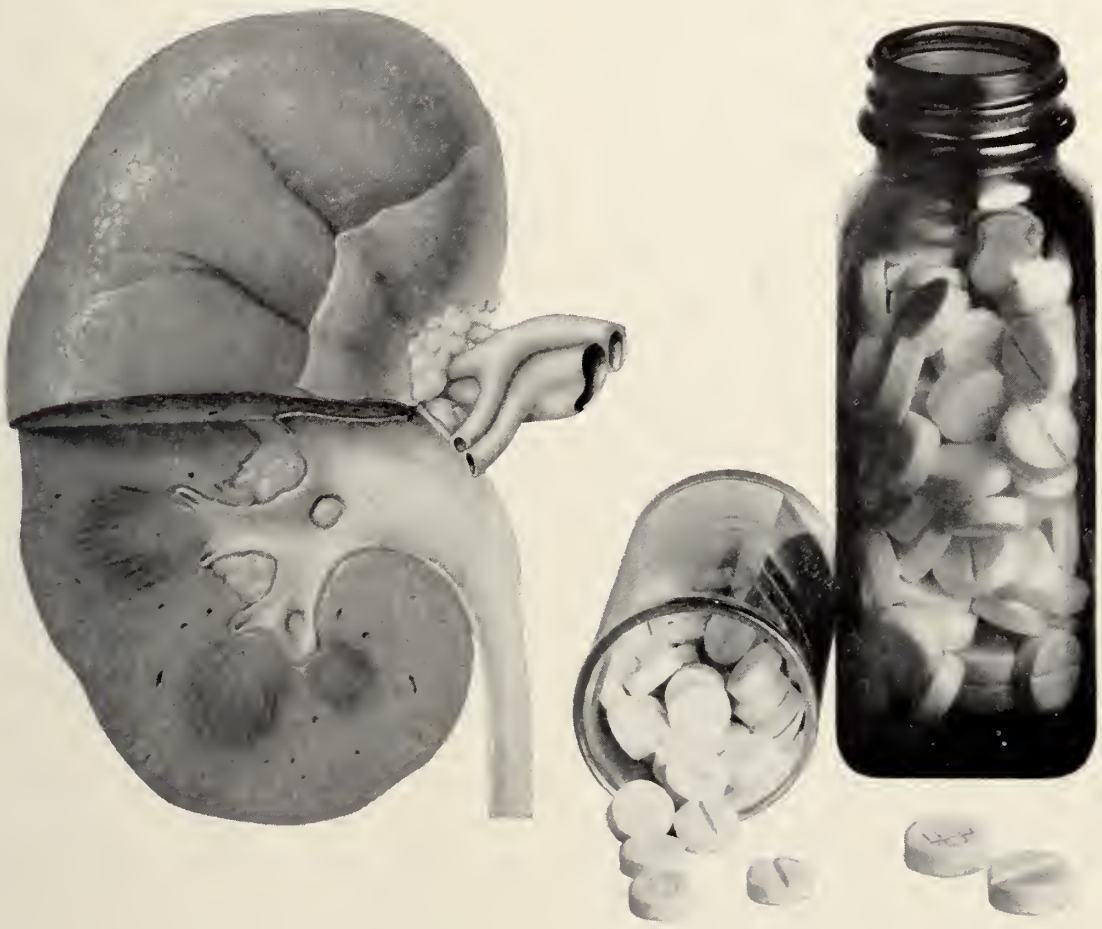
Contraindications: Patients sensitive to barbiturates. Use with caution in the presence of moderate to severe hepatic disease.

Supplied: Bottles of 100 tablets.

CAUTION: Federal law prohibits dispensing without a prescription.

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understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

• Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

(Continued from Page 1066)

tributed to increased emphasis on planned parenthood. The provisional figure for births during the past year indicates the lowest birth rate recorded in the state since 1919.

Infant and neonatal deaths declined during 1965. This was largely due to increased activity in Maternal and Child Care. Phase III of the Immunization Program began in 1965 and established an on-going maintenance program to insure that each child born to a resident of Alabama is immunized before his first birthday. Fifty immunization billboard posters were placed throughout the state. During July and August, 2,800,000 callers in Jefferson County listened to Birmingham Trust National Bank's Telephone time service messages, "Help bring immunity to our community," and "Make a date to vaccinate." Premature infant care activities increased. Portable incubators and portable oxygen equipment were distributed to county health departments. Specialized and conventional incubators were also supplied to certain hospitals throughout the state. The phenylketonuria testing program was legally established by a 1965 Legislative act and the Bureau of Laboratories processed 56,098 of these tests. Four cases were identified and are under treatment.

Health education techniques have been used extensively to insure the health of Alabama's younger citizens. Alabama's electronic tree of knowledge was tapped with a series of elementary health science programs video taped and presented over educational television to third through sixth grade students throughout the state.

The Bureau of Dental Hygiene published "A Guide for Teaching Dental Health in Alabama Schools" representing a first in health for Alabama school children. This program will reach more than half of the 20,000 elementary teachers in Alabama during the first year.

Promotion and implementation of Medical Self-Help Programs were accelerated. During 1965 Alabama consistently ranked among the top 10 states in numbers of individuals trained.

The number of chronically ill and aging in Alabama increased. Programs designed to increase and improve the health and welfare of these senior citizens were accelerated in 1965. The Division of Medical Care reviewed approximately 30,500 hospital and 7,000 physician's hospital claims during the year. Sixteen counties administered home care for the sick programs. A total of 40,373 home visits were made during the year by Public Health nurses.

The Alabama Department of Public Health is never static. Continuous change was necessary as old problems were solved and new ones brought about by technical progress. The task of providing quality health services and of blazing trails in new fields of activity is the ever present objective of the Department. Modern public health programs require us to sprint to stay even with scientific advances in a time of expanding technology.

THE QUEST FOR QUALITY IN DRUGS

As many studies show, all drug products having the same generic name are not identical. Some generic-name drug products are of excellent quality; some are not. Unless the product (whether marketed under generic or brand name) is made by a reputable and qualified manufacturer, there is absolutely no way to tell which is good and which poor—before it is used—without the use of analytical and biological facilities more elaborate than most physicians, pharmacists and hospitals are likely to possess. A. E. Slesser, Ph. D., in *Arizona Medicine*, (22:826), October 1965.

The Continuing TB Threat

Alabama ranks eighth in the nation in numbers of new active TB cases reported, and second in the nation for TB death rates. As of December 31, 1965, there were nearly 9,000 TB cases in the State Central Registry. Of these, 3,613 were active according to the latest report. Only 1,078 of these active cases were hospitalized which leaves 2,535 active cases at home requiring intensive treatment and close medical supervision. Over twice as many known active TB cases are being treated at home as in the hospital. The records of our county health departments indicate that a majority of the nearly 8,000 home cases are delinquent regarding X-ray, laboratory examination, and/or treatment.

During 1965 there were 1,417 new active TB cases reported in Alabama. This represents a 12 per cent increase over those reported in 1964. Breaking these cases down as far as race, sex, age, and geographical location are concerned, we find the following:

There were more cases of TB reported among white than among colored patients. The case rates, however, among the colored population are twice as high as the white rates.

Twice as many cases of tuberculosis were reported among males as among females in Alabama during the year.

Over half of Alabama's new cases occur and are reported among persons over 45 years of age. Nearly half of the new cases are reported from the larger cities of Alabama—Birmingham, Montgomery, Mobile, Tuscaloosa, Gadsden, and Huntsville.

The U. S. Public Health Service estimates that there are 35 million people in the United States who are presently infected with and harbour the germ causing organism of TB. Fortunately, most of these infected persons who react to a tuberculin test will never have active tuberculosis. However, each year some of these infected individuals break down with tuberculosis.

About three-fourths of the newly reported cases of tuberculosis in Alabama are thought to be due to such a breakdown. If three-fourths of the new cases come from this group, then it is impossible to eradicate TB in our lifetime. To eradicate tuberculosis children must be prevented from being exposed to TB, allowing them to grow up without being infected.

The contact investigation is the most productive means of case-finding. These persons not only have a considerable likelihood of having active disease when first examined, but they have a high risk of developing the disease during the year following diagnosis of the active case. The risk for contacts breaking down with active disease is greatly reduced by the administration of prophylactic INH for one year.

Dr. W. H. Y. Smith, Director, Bureau of Preventable Diseases, established a pilot study program for prophylactic treatment of household contacts in 1963 in Alabama. To date, nearly 2,000 contacts are on this drug program; not a single breakthrough of active disease has occurred among the contacts who continued drug therapy. All 67 counties are presently on this program.

Special tuberculosis projects are being conducted in counties within the state by the Bureau of Preventable Diseases. Counties included are as follows: Mobile, Baldwin, and Escambia counties; Colbert, Lawrence, Lauderdale, Limestone, and Morgan counties; and Montgomery, Dallas, Lowndes, and Autauga counties. These areas represent the highest tuberculosis case rates in Alabama.

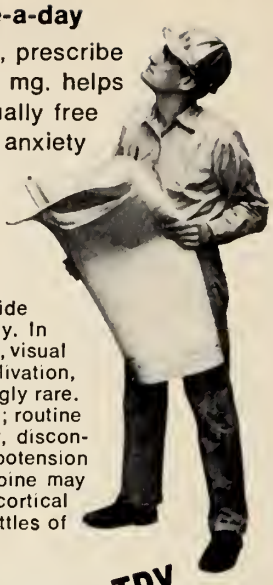
Full-time tuberculosis nurses, male investigators, and tuberculosis clerks have been assigned to these districts to assist with the ongoing tuberculosis control programs. Clinics are being established which include the services of an experienced chest physician at the local health departments in an attempt to bring badly needed medical services to the tuberculosis patient.

In the five-county North Alabama District, considerable improvement has been shown

(Continued on Page 1073)

Blueprint for dealing with tension due to stress — Prolixin — once-a-day

For the patient who must be on the job mentally as well as physically, prescribe Prolixin. The prolonged tranquilizing action of as little as one or two mg. helps him cope with tension all day long. Markedly low in toxicity and virtually free from usual sedative effects, Prolixin is effective in controlling both anxiety associated with somatic disorders and anxiety due to environmental or emotional stress. Patient acceptance is good — because Prolixin is low in cost, low in dosage and low in sedative activity. Prescribe Prolixin.



Side Effects, Precautions, Contraindications: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photosensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders. **Available:** 1 mg. tablets. Bottles of 50 and 500. For full information, see Product Brief.

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THE CONTINUING TB THREAT

(Continued from Page 1071)

after one year of special project operation. The per cent of active cases under treatment has increased from 58 per cent to 70 per cent. Active cases at home receiving sputum examinations in the past six months has increased from 37 per cent to 65 per cent. The percentage of contacts examined has increased from 72 per cent to 82 per cent.

The need for further development of these programs is exemplified by the increased number of new cases being reported throughout the state.

BUREAU OF LABORATORIES

Thomas S. Hosty, Ph.D., Director

APRIL 1966

Examination for intestinal parasites	1,459
Examination for Malaria	2
Salmonella & Shigella (blood, feces, urine and other)	245
Examination for tubercle bacilli	3,739
Examinations for gonococci	1,808
Serological tests for syphilis	27,089
FTA	24
Darkfield	2
Brucella	1
General Bacteriology (cultures for isolation and confirmation)	25
Staphylococcus (cultures for isolation and confirmation)	179
Examinations for diphtheria	23
Streptococci examinations	2,040
Mycology	21
Agglutinations	13
Vincent's Infection	0
Complement Fixation tests	415
Tests for Phenylketonuria (PKU)	5,174
Cytology	673
Water examinations	2,630
Milk and dairy products examinations	3,388
Sea food examinations	146
Examination for Negri bodies (smears and animal inoculation)	324
Virology	6
Miscellaneous	844
Total	50,270

BUREAU OF PREVENTABLE DISEASES

W. H. Y. Smith, M. D., Director

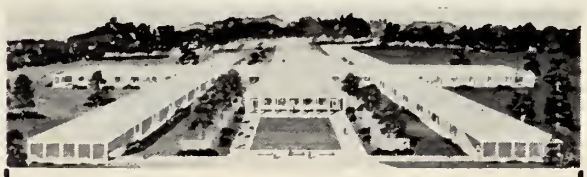
Current Morbidity Statistics

1966

	March	April	*E. E. April
Tuberculosis	101	119	119
Syphilis	181	150	142
Gonorrhea	335	338	282
Chancroid	2	0	2
Typhoid fever	1	1	0
Undulant fever	0	0	0
Amebic dysentery	4	4	6
Scarlet fever & strep. throat	512	519	151
Diphtheria	2	0	1
Whooping cough	1	1	9
Meningitis	13	15	7
Tularemia	2	0	0
Tetanus	1	1	1
Poliomyelitis	0	0	0
Encephalitis	2	1	1
Smallpox	0	0	0
Measles	441	526	502
Chickenpox	137	135	243
Mumps	31	23	102
Infectious hepatitis	34	43	37
Typhus fever	0	0	0
Malaria	0	0	0
Cancer	437	1,435	662
Pellagra	0	4	0
Rheumatic fever	19	19	13
Rheumatic heart	29	28	25
Influenza	4,313	4,204	674
Pneumonia	548	522	263
Rabies—Human cases	0	0	0
Pos. animal heads	0	5	0

As reported by physicians and including deaths not reported as cases.

*E. E.—The estimated expectancy represents the median incidence of the past nine years.



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BUREAU OF VITAL STATISTICS
PROVISIONAL BIRTH AND DEATH STATISTICS AND COMPARATIVE DATA

FEBRUARY 1966

Ralph W. Roberts, M. S., Director

Live Births Deaths Causes of Death	Number Registered During February 1966			Rates* (Annual Basis)		
	Total	White	Non-White	1966	1965	1964
Live Births	5,350	3,401	1,949	19.8	20.1	22.6
Deaths	2,726	1,724	1,002	10.1	9.6	9.4
Fetal Deaths	91	41	50	16.7	19.5	14.8
Infant Deaths						
under one month	94	49	45	17.6	18.8	19.8
under one year	171	78	93	32.0	36.1	34.5
Maternal Deaths	3	1	2	5.5	5.5	9.7
Causes of Death						
Tuberculosis, 001-019	17	10	7	6.3	4.5	7.4
Syphilis, 020-029	3	3		1.1	1.9	1.5
Dysentery, 045-048					0.7	
Diphtheria, 055						
Whooping cough, 056					0.7	
Meningococcal infections, 057	3	2	1	1.1		0.7
Poliomyelitis, 080, 081						0.4
Measles, 085					1.5	
Malignant neoplasms, 140-205	317	235	82	117.3	112.0	101.9
Diabetes mellitus, 260	39	21	18	14.4	19.1	13.3
Pellagra, 281	1	1		0.4		
Vascular lesions of central nervous system, 330-334	384	233	151	142.1	125.8	136.4
Rheumatic fever, 400-402	1		1	0.4	0.4	0.4
Diseases of the heart, 410-443	930	658	272	344.3	318.8	329.9
Hypertension with heart disease, 440-443	109	48	61	40.3	36.0	48.6
Diseases of the arteries, 450-456	67	49	18	24.8	20.6	20.8
Influenza, 480-483	9	4	5	3.3	6.7	3.0
Pneumonia, all forms, 490-493	133	71	62	49.2	37.8	35.2
Bronchitis, 500-502	8	8		3.0	4.1	2.2
Appendicitis, 550-553	5	3	2	1.8	0.4	1.5
Intestinal obstruction and hernia, 560, 561, 570	18	12	6	6.7	3.7	4.8
Gastro-enteritis and colitis, under 2, 571.0, 764	8	5	3	3.0	5.2	6.3
Cirrhosis of liver, 581	21	12	9	7.8	4.1	4.8
Diseases of pregnancy and childbirth, 640-689	3	1	2	5.5	5.5	9.7
Congenital malformations, 750-759	19	15	4	3.6	6.3	5.1
Immaturity at birth, 774-776	20	9	11	3.7	4.1	5.1
Accidents, total, 800-962	184	109	75	68.1	71.2	52.3
Motor vehicle accidents, 810-835, 960	71	47	24	26.3	36.7	18.2
All other defined causes	356	204	152	131.8	130.3	133.1
Ill-defined and unknown causes, 780-793, 795	180	59	121	66.6	64.8	60.0

*Rates: Birth and death—per 1,000 population
Infant deaths—per 1,000 live births
Fetal deaths—per 1,000 deliveries
Maternal deaths—per 10,000 deliveries
Deaths from specified causes—per 100,000 population



An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
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(meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

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DR. SAMUEL BARKER DIRECTS CENTER GRADUATE STUDIES



Dr. Samuel B. Barker

History is rich with accounts of man's achievements, particularly his phenomenal ability to unravel the mysteries of his physical environment. Unfortunately, he has had comparatively less success in developing an understanding of the basic life processes that take place within his own body.

Dr. Samuel B. Barker, the new Director of Graduate Studies at the University of Alabama Medical Center, has devoted the major portion of his professional life toward more understanding of these processes. If one single quality could best characterize this scientist, it would be intellectual curiosity, a joy in learning for just the sake of learning. For some 35 years, Dr. Barker's interests have been focused primarily on the life processes, and more specifically, mysteries of the thyroid gland and its secretions.

After graduating cum laude from the University of Vermont, he began training for the Ph. D. at Cornell University. His graduate training intensified his knowledge of the basic sciences with an emphasis on endocrinology. Some of his graduate studies and later postdoctoral work resulted in several significant contributions. One of his first and most important achievements was the development of a quantitative test for lactic acid in the blood or in any biological material. This analytic method is still being used in research of carbohydrate metabolism.

Another important result of Dr. Barker's work was a test for urea, a nitrogen-containing substance which is an end product of protein metabolism. The basic procedure formulated by Dr. Barker some years ago is still followed, and was adopted in the development of automatic analyzers.

A third analytic procedure provided one of the first and most effective methods of quantitatively measuring the presence of protein-bound iodine (PBI), which is primarily the thyroid hormone, thyroxine. This procedure has had wide clinical application, and although the presently-used PBI test has been modified to some extent by later developments, Dr. Barker's original work still forms the basis for today's test. Actually, Dr. Barker developed two PBI analytic procedures, one of which received wide acceptance in the early days of protein-bound iodine testing, the latter one coming into more recent usage.

The major portion of Dr. Barker's present work is still concerned with studies of thy-

roxine and its components. This hormone, which is the most important factor in the development of animals is easily extracted from the thyroid, or synthesized in the laboratory for study. Therefore, Dr. Barker and his colleagues have been experimenting extensively with the various components of the thyroxine molecule. They have substituted one or more of the components, or varied their normal positions. In some cases they have found alteration of the various componens will produce the same results as thyroxine; in other cases changes will nullify its action. Sometimes a variation will produce a more intense reaction; other times, simply less reaction. These experiments have produced more understanding of which components as well as their relative placements are most responsible for the hormonal reactions.

Dr. Barker emphasizes that these studies are aimed, not at clinical application, but toward more understanding of the way this amazing hormone works. "If a clinical application results from our work, we are delighted," he says, "but we are engaged in basic research. This kind of work should be, and most often is, a necessary forerunner of all clinical treatment. We must know as much as possible about all the life processes before we can intelligently correct disease in human beings."

Yet another study, still related to the thyroid, but involving a different approach, is a comprehensive investigation of the metamorphosis of the frog. One specific aspect is an analysis of the "sodium pump" which controls the flow of sodium through the skin of the frog. Dr. Barker's group have found that some factor in the frog's skin permits a rate of salt flow into the frog which exceeds the amount allowed to escape.

"Just why this phenomenon exists, we aren't sure. We are trying to find out more details of its mechanism. This is another case of learning for the sake of learning, but it may lead to better understanding of its purpose. Who knows what its implications will be, in the final analysis?"

Studies with the frog have also indicated that thyroxine-related compounds have a variable effectiveness similar to that found in other research animals, and in human beings.

Dr. Barker has been in the academic field since his graduate-study days. He has held academic appointments at several institutions, among them Cornell University Medical College (Assistant in Physiology, 1937-40 and Fellow in Medicine, 1938-41); University of Tennessee College of Medicine (Instructor in Physiology 1941-43, Assistant Professor of Physiology, 1934-44); State University of Iowa College of Medicine (Assistant Professor of Physiology, 1944-46, Associate Professor of Physiology, 1946-52); Medical College of Alabama and the University of Alabama School of Dentistry (Professor of Pharmacology, 1952-62); College of Medicine, University of Vermont (Professor of Pharmacology, 1962-65). He is now Director of Graduate Studies and Professor of Physiology at the University of Alabama Medical Center, and Associate Dean, Medical College, and School of Dentistry, University of Alabama.

Dr. Barker's work has brought him recognition at a number of levels. He has served as an advisor to the National Institutes of Health almost since its inception in the early 1940's. During World War II years, and for slightly thereafter, he served as an advisor to the Office of Scientific Research and Development.

As an established scientist, he took two sabbaticals for special work and study in endocrinology: In 1951, he worked for a year at the University of California in Los Angeles under a Krichesky Fellowship; In 1961-62, he received a special NIH Career Award to study at the University of Edinburgh, with a group of colleagues interested in similar research.

Dr. Barker's contributions to the under-

(Continued on Page 1080)

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Use with caution in lower than usual doses in cases with renal impairment to avoid accumulation of tetracycline and possible liver toxicity. If therapy is prolonged under such circumstances, tetracycline serum levels may be advisable. In long term therapy or with intensive treatment or in known or suspected renal dysfunction, periodic laboratory evaluation of the hematopoietic, renal and hepatic systems should be done. Formation of an apparently harmless calcium complex with tetracycline in any bone forming tissue may occur. Use of tetracycline during tooth development (3rd trimester of pregnancy, infancy and early childhood) may cause discoloration of the teeth. Reversible increased intracranial pressure due to an unknown mechanism has been observed occasionally in infants receiving tetracycline. Glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis and definite allergic reactions occur rarely. Severe anaphylactoid reactions have been reported as due to triacetyloleandomycin. Photosensitivity and photoallergic reactions (due to the tetracycline) occur rarely. Medication should be discontinued when evidence of significant adverse side effects or reaction is present. Patients should be carefully observed for evidence of overgrowth of nonsusceptible organisms including fungi, which occurs occasionally, and which indicates this drug should be discontinued and appropriate therapy instituted. Steps should be taken to avoid masking syphilis when treating gonorrhea.

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(Continued from Page 1077)

standing of the action of the thyroid gland brought him an invitation to speak at a CIBA Foundation Colloquium on "Regulation and Mode of Action of the Thyroid Hormone". This symposium was held in England in 1956.

Dr. Barker is the co-author of the standard text, *Basic Endocrinology.*

He is a member of the following scientific societies: American Association for Advancement of Science; American Physiological Society; Society for Experimental Biology and Medicine; Harvey Society; American Association of University Professors; Alabama Academy of Science: President 1959-60; American Federation for Clinical Research; Endocrine Society; American Chemical Society; Biochemical Society (London); New York Academy of Sciences; American Thyroid Association.

Ban On Brands—A Body Blow

There is certainly room for generic drugs. But the effort to curb the branding of all drugs would be a disastrous body blow to the public. Countless research efforts, conducted at heavy expense both in money and manpower, come to nothing. Others produce valuable but specialized drugs, needed and used by but a few people who would die without them. The successful drugs in wide use must carry the costs. There is no other way. A trade name is the producer's guarantee of quality. And it rewards research and development which mean help to sufferers from the endless ailments which plague mankind. Why put a b r a k e on medical progress—the road to ever better health.—Editorial in *St. Louis County Medical Society Bulletin*, (32:5) February 18, 1966.

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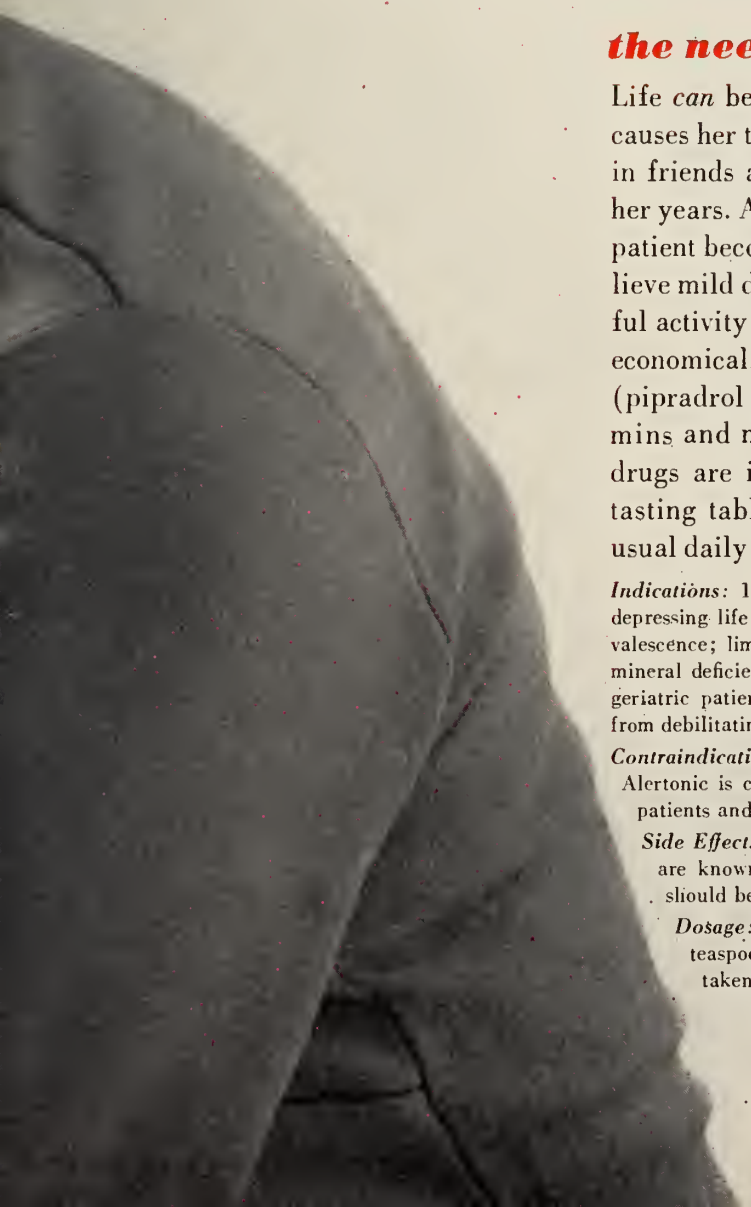
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The Month in Washington

From the Washington Office
American Medical Association

Washington, D. C.—The importance of the role of the general practitioner is emphasized in the recommendations of the National Commission on Community Health Services to President Johnson.

The Commission said that everyone should have a personal physician, even under the group practice system. Under these conditions, the commission added, group practice should be stimulated. It is essential that the physician-patient relationship be strengthened "if comprehensive personal health services of high quality for each individual are to be achieved," the commission said.

"The long range import of the recommendation of having the personal physician assume responsibility as the central source for preventive health service and continuing care, most particularly its impact on medical education, is well appreciated.

"The possibility of attracting a sufficiently large number of medical graduates to careers as personal physicians presupposes a general recognition of the importance of the role and commensurate rewards in professional satisfaction and income comparable to that of other physicians. In all its ramifications, the national effort must be comparable in magnitude to that which expanded medical research personnel in the last two decades. Large scale financing will be necessary for the support of teachers, students, facilities, programs and educational research."

Other commission recommendations included: breaking down eventually all separate systems of health care such as for veterans, labor members, merchant seamen, and the medically indigent; orienting all health care services on a community basis.

President Johnson endorsed the recommendations, but predicted that it would be many years before they would be fully implemented.

The commission is a private, non-profit study group formed in 1962 by the National Health Council and the American Public Health Association. Thirty-two members from medicine, business, labor and other fields make up the commission, which is headed by Marion B. Folsom, former Secretary of Health, Education and Labor.

"To achieve an integrated program which will provide comprehensive personal health services of high quality to all in each community, it will be necessary to weld together many separate programs into a community-wide program," the commission said. "Accomplishment of this goal would preclude new construction or the expansion of hospitals for these separate groups, and would require total integration of such facilities into the total community services. Financing . . . will continue to come from a variety of resources."

* * *

The National Academy of Sciences—National Research Council will undertake for the Food and Drug Administration a new evaluation of the efficacy of about 4,000 prescription drugs, starting this summer.

"The determination of the efficacy of new drugs marketed from 1938 to 1962 is called for under the Kefauver-Harris Amendments of 1962," Dr. James L. Goddard, FDA Commissioner said.

"I am grateful that the National Academy, with its capability of calling upon the talents of the nation's most distinguished scientists,

is willing to accept this important public responsibility."

The review will be the most extensive efficacy study of drugs ever undertaken, Goddard said. Results of the study will guide the FDA in its final determination of the effectiveness of the drugs.

Since October, 1962, manufacturers have been required under the Kefauver-Harris Amendments to submit substantial evidence to support therapeutic claims before receiving FDA approval to market a new drug. The NAS-NRC review will put to the efficacy test new drugs marketed under the provisions of 1938 legislation, which required only a showing that drugs were safe for their intended use. The 1938 Act excluded from FDA approval procedures drugs already on the market, as well as drugs introduced after that date that were generally recognized as safe by qualified experts.

Dr. James Z. Appel, president of the American Medical Association, sharply criticized the FDA's enforcement of the 1962 Drug Act Amendments in a speech at Chicago. He listed 10 counts on "the minus side" of the FDA record on administering the amendments.

"The manner in which the Agency suddenly seizes drugs and accompanies this activity with alarming language tends to create an atmosphere of hysteria," Appel said. "It also is creating a restrictive and undesirable medico-legal climate that will inevitably exert a deleterious influence on the effective use of drugs by the physician. This trend is causing the medical profession much concern . . .

"Nagging us is the increasing suspicion that regulatory decision may be dictated more by the technicalities of regulatory language than by appeal to competent medical and scientific analysis and judgment. The tame submission of the pharmaceutical industry to any and every regulatory suggestion or directive, regardless of the medical and scientific facts involved, is unsettling . . .

"At the time of the passage of the 1962 amendments and subsequent regulations, we were concerned about the advisability of non-medically oriented lay FDA inspectors being permitted to inspect and copy the case records of physicians engaged in clinical investigation. This could only result in a non-professional acting as a judge in a professional area and also invading the physician-patient relationship. We have been apprised of incidents where such inspection has extended even to the personal file of an investigating physician. The future implementing of this aspect of drug investigation cannot help but concern us."

* * *

The AMA has reiterated its support of a federal program to aid in modernization of hospitals.

Dr. F. J. L. Blasingame, executive vice president of the AMA, wrote the Senate Health Subcommittee that the AMA supports that provision of an Administration bill (S. 3009) that would provide grants and loans for modernization of hospitals and other medical facilities, through direct federal loans, government guarantee of private loans, and also federal grants with respect to loans, amortizing principal and interests payments thereon up to 40% of the cost of a project.

"While the present Hill-Burton program does provide for modernization of hospital facilities with priority 'in the case of projects for modernization of facilities, to facilities serving densely populated areas,' we nevertheless feel, because of the great need which exists, that the special program contemplated under S. 3009 for modernization of facilities in metropolitan areas is indeed warranted," Blasingame said.

The AMA opposed some other provisions of the legislation. It was recommended that aid for diagnostic or treatment centers be eliminated and that federal money be available to only those public health centers operated by a public health department.



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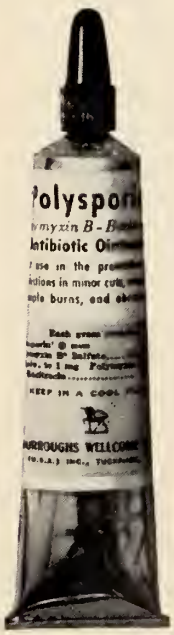
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Contraindications: Infants, patients with history of convulsive disorders or glaucoma.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal or hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effeets: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

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THE JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

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Entire Board Of Directors Pledges Ear Bones To Science

All members, and their wives, of the Board of Directors of the National Association of the Deaf have bequeathed their inner ear structures to ear research scientists.

The donation was cited by Dr. Gordon Hoople, Medical Adviser to the Deafness Research Foundation, as "the most significant and unique contribution ever made by the deaf to the cause of otologic research.

"This unprecedented action on the part of these enlightened leaders of the deaf may well pave the way to reaching new insights into nerve deafness through the example it will set for thousands of the profoundly deaf," Dr. Hoople said.

Medical Center Statistics

The Schools of Medicine, Dentistry, and Nursing had the largest enrollment of all divisions of the University of Alabama Medical Center for the 1965-1966 school year, according to statistics recently published by the Center.

The School of Medicine had a total of 298 full-time students, including seven women. Dentistry had 185 men and four women students while seven men and 165 women were enrolled in the School of Nursing.

The remainder of the 898 medical students were enrolled as follows: 24 in postgraduate dentistry, 118 doing graduate studies, 20 in nurse anesthesia, 19 in medical technology, 39 in radiological technology, six as laboratory assistants, two in cytotechnology, three in blood bank technology, and eight in physical therapy.

In addition, 187 other students are serving internships and residencies.

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